Arizona Department of Health Services
Division of Public Health Services

Office of Health Systems Development
PRIMARY CARE PROGRAM

PROGRAM GUIDANCE MANUAL

Revised October 2004

TABLE OF CONTENTS

MANUAL ORGANIZATION

This manual provides guidance for Primary Care Program Contractors as they provide covered services to eligible uninsured individuals. The manual contains information necessary to meet the contract compliance standards for the program and serves as a reference guide for program activities during the term of the contract. The manual shall be used as a standard of performance for regular program reviews and evaluations.

A copy of the Program Guidance Manual should be maintained at each contracted service site. Contractors' staff, responsible for providing services under this contract, should be familiar with the information included in this manual. The Arizona Department of Health Services (ADHS) may revise the manual during the contract year. ADHS will provide any revisions to Contractors for inclusion or replacement in their manuals. It is the Contractors' responsibility to insure that site copies of the manual are updated with any revision materials.

Part I: Contains a brief description of the Primary Care Program and a summary of the program's goals and intent.

Part II: Describes general program compliance, program management and eligibility determination.

Part III: Describes covered primary care services and requirements.

Part IV: Contains program standards for record maintenance, quality assurance and licensure/certification.

Part V: Details financial requirements, including billing and payment procedures.

Part VI: Provides information about required reports and their due dates.

The Appendices contain definitions, procedures to be followed when documenting a client's eligibility, and formats to be used when responding to the reporting requirements of the program.

Contractors may refer any questions regarding this manual to the Office of Health Systems Development (HSD) at 602.542.1219.

PART I: PRIMARY CARE PROGRAM

The Primary Care Program funding is designed to assist communities in meeting the reasonable costs of providing primary care services to eligible clients. The amount and duration of assistance will be determined by factors such as the agreed upon needs for service delivery; the availability of funding to meet those needs; and Contractor performance. All Primary Care Program Contractors shall provide the full range of covered services to eligible Arizona residents as listed in Part III. The following information provides a brief overview:

A. Summary of General Intent:

The goal of the Primary Care Program (PCP) is to develop and maintain an enhanced statewide capacity for delivery of comprehensive, community-based primary care services to low-income, uninsured persons and other medically underserved Arizona residents. PCP providers should strive to exhibit the essential attributes of a Primary Care System (PCS) as described in Appendix C. By developing partnerships and networks for referrals to other health services for PCP clients, PCP providers operate as part of a coordinated Primary Care System.

B. Summary of Funded Activities:

Funds shall be used for the provision of primary and preventive care services and preventive dental services to Arizona residents eligible for the PCP. The Contractor shall directly provide or arrange for the provision of all covered services. The sliding fee scale is applied to all covered services whether the Contractor provides the services directly or arranges for the services. The Contractor may formally arrange to pay for the services directly and charge the client according to the sliding fee scale, or may formally arrange for the client to pay the other provider according to the sliding fee scale.

C. Program Goals:

1. Identify uninsured, low-income, at risk individuals in targeted communities and facilitate their entry into the program.

2. Increase access to primary care services for uninsured persons in the state through expansion of primary care services.

3. Support fully developed primary care systems that exhibit the essential attributes of a Primary Care System (PCS).

4. Reduce health disparities among racial/ethnic minorities and other disenfranchised populations.

The Primary Care Program, originally known as the Tobacco Tax Primary Care Program, continues to draw upon the original legislation for basic direction.

PART II: PROGRAM REQUIREMENTS

A. General Compliance

The Contractor is responsible for complying with all the terms and conditions of the contract. It is the responsibility of the Contractor to thoroughly understand the contents of this manual. The Contractor shall comply with appropriate Rules, including but not limited to the Arizona Administrative Code Sliding Fee Schedule, contained in Appendix B. The Contractor should contact HSD when technical assistance or clarification is needed.

B. Program Management

Management responsibilities include, but are not limited to the following requirements:

1. Maintain appropriate and qualified administrative and support staff;
2. Organize and operate service delivery;
3. Recruit and retain appropriately licensed/certified service providers;
4. Maintain referral, information and coordination networks;
5. Maintain and assure quality of services;
6. Prepare, maintain and submit program documentation, reports, and data;
7. Maintain contract compliance.

C. Client/Staff Satisfaction Surveys

Contractors are <u>required</u> to conduct an annual client satisfaction survey to ensure that views of service users are incorporated into decisions involving the provider's policies, priorities, plans and operations. Contractors are encouraged to conduct staff satisfaction surveys as well. These surveys shall be available on-site for ADHS review and shall be submitted to ADHS upon request.

D. Notice requirements

The Contractor shall notify the general public and the Contractor's patients that:

1. The Contractor is providing primary care services funded by the Arizona Department of Health Services Primary Care Program.
2. Interested persons may apply for primary care services from the Contractor.
3. Services will not be denied based on an individual's inability to pay.

Notices indicating the availability of sliding fee scale services shall be posted in all client waiting areas at all service sites. Notices shall be in English and Spanish.

E. Eligibility Requirements

In order to be eligible for the Primary Care Program, applicants must meet the following eligibility requirements:

1. Be a resident of the state.
   A child enrolled in a school within the state may be considered an Arizona resident. A person who declares him/herself to be homeless may be considered an Arizona resident.

2. Be without health insurance coverage.
   AHCCCS/KidsCare and MEDICARE: Eligibility for or enrollment in AHCCCS, KidsCare or Medicare is considered health insurance. Persons enrolled in AHCCCS/KidsCare shall be referred to their AHCCCS health plan for services. Persons enrolled in Medicare may be treated by the Contractor and billed to Medicare, if the Contractor is a Medicare provider, or the person shall be referred to a Medicare provider.

   INDIAN HEALTH SERVICES: Eligibility for Indian Health Services (IHS) is not considered health insurance coverage. Members of federally recognized Indian tribes are not considered to be insured by Indian Health Services (IHS) and are considered eligible for PCP-funded primary care services if they meet all other eligibility criteria. However, IHS-AHCCCS enrollees are not eligible for PCP services.

3. Have a gross annual **family** income no greater than two hundred percent of the federal poverty level (FPL) guidelines.
   The federal poverty guidelines are established annually by the U.S. Department of Health and Human Services. The guidelines are updated in the first quarter of the calendar year and are listed in the Federal Register, which may be found on the Internet at http://aspe.os.dhhs.gov/poverty. See Federal Poverty Level Guidelines in Appendix A.

F. Eligibility Determination

1. The Contractor shall verify with AHCCCS Administration that the person is not enrolled in an AHCCCS/KidsCare program.

2. The Contractor shall provide full documentation of eligibility for every person who receives services under the PCP. The initial eligibility information may be self-declared by the applicant. If the declared information meets the PCP eligibility requirements, the applicant is "presumptively" eligible for services. It is the Contractor's responsibility to verify (e.g., check stubs, statements from employers, utility bills, statements from landlords, AHCCCS denial letter, etc.) eligibility.

3. To insure compliance with legal mandates, PCP-funded services shall not be provided indefinitely to persons who may be eligible for AHCCCS/KidsCare services. Contractors may utilize PCP funds to treat patients awaiting AHCCCS/KidsCare determination in a "presumptively eligible" status for up to six weeks. After the six-week period, if AHCCCS/KidsCare eligibility determination has not been completed, the person shall not be served with PCP funds. Any person who is referred to AHCCCS/KidsCare but refuses to seek AHCCCS/KidsCare determination or fails to complete the application process shall not be served with PCP funds.

Note: the six-week period is intended to allow for processing of AHCCCS applications. It is not the intent of the presumptive period to allow a full six weeks for clients to present documentation of their income and Arizona residency. Clients must provide income and residency documentation prior to their next clinic visit.

The presumptive eligibility period may be used only once for each client and may not be extended due to a delay in receipt of income or residency documentation from the client.

4. Eligibility for AHCCCS/Kidscare and Medicare shall be verified as outlined in Sections B.4 and B.5 of Appendix E. An AHCCCS denial letter is required as verification that the person who appears to meet AHCCCS/KidsCare preliminary eligibility based on income or chronic illness (spend-down) has applied and been deemed ineligible for AHCCCS/KidsCare. For persons who do not appear to meet AHCCCS/KidsCare eligibility criteria (e.g., over income, non-citizen), a denial letter is not necessary. However, the Contractor must annotate in the eligibility file the reason why the person is ineligible.

5. Once a person is deemed eligible to receive PCP-funded services, it is suggested that the Contractor has clients sign a statement of understanding or Decision Notice such as the form illustrated in Appendix G of this manual. This acknowledges the person's understanding of their financial responsibility as well as the limitations of service coverage.

6. A PCP Contractor shall submit eligibility and encounter data only for those persons who have successfully completed the Contractor's eligibility determination process.

G. Eligibility Re-determination.

All eligible persons shall have their eligibility re-determined every twelve months, or more frequently if their family size, insurance status or financial situation changes. Contractors are encouraged to verify continued eligibility at each primary care provider visit.

H. Eligibility Documentation

1. The Contractor shall maintain eligibility documentation for each client served with Primary Care Program funds for audit purposes. A copy of the client's eligibility determination form shall be maintained in the client's file. See Appendix E for the required form and Appendix D for the description of the eligibility procedures.

2. The Contractor shall provide eligible persons with verification of their eligibility. The verification may be a copy of the completed eligibility form. The document provided to eligible persons must include at least the following:

   a. Date eligibility was established
   b. Name of eligible client
   c. Standardized Patient Identification (SPID)
   d. Name, address and phone number of the Contractor, including a 24-hour phone number.
   e. A disclaimer stating that the PCP is not insurance and does not cover emergency and/or hospital services.

I. Sliding Fee Schedule/Sliding Fee Scale (SFS)

1. Contractors shall submit their Sliding Fee Scales to ADHS for approval prior to implementation.

2. Contractors shall comply with the requirements of Arizona Administrative Code R9-2-101 (Appendix B), including the requirement to apply a 100% discount to charges for individuals with an income below 100% of the federal poverty guidelines.

3. The Contractor shall not require payment for services prior to a client receiving services. Eligible clients shall not be refused services if they are unable to pay their portion of the sliding fee schedule charges. The unpaid portion of charges that are the client's responsibility shall not be represented as uncompensated care. The Contractor may consider the unpaid portion as "bad debt."

4. All service charges to eligible clients shall be according to the Contractor's approved SFS. The client's payment for all covered services provided, whether provided by the Contractor or through referral, shall be based on the SFS.

PART III. COVERED PRIMARY CARE SERVICES and REQUIREMENTS

A. OUTREACH SERVICES

Outreach is the process and activities by which members of the target community are made aware of the services and benefits of the program. This includes efforts to inform the entire community at-large of the program and its services, and to inform potential clients by personal contact or mailings. Assisting potential clients with the eligibility process is an important element of outreach. Outreach activities should be reported to ADHS in the quarterly progress report.

Contractors shall develop partnerships with their county health department and with their community emergency medical services provider(s). Evidence of these partnerships shall include activities such as participation in community health workgroups, task forces and coalitions and collaborative ventures such as health fairs, outreach programs and continuing medical education activities.

B. PRIMARY and PREVENTIVE HEALTH SERVICES

Primary care means health services and medical care provided by or under the authority of licensed primary care physicians and licensed mid-level primary health care providers as defined in section A.R.S. § 36-2171. Primary care includes health promotion, disease prevention, health maintenance, behavioral counseling, patient education, diagnosis and treatment of acute and chronic illnesses.

Contractors shall provide immunizations and screenings in accordance with the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) periodicity schedule (see Appendix L). Contracted primary care providers shall manage chronic disease conditions (i.e., diabetes, HIV/AIDS, etc.) to the extent of the standard primary care scope of practice. Problems or conditions requiring specialty care are not covered by the Primary Care Program and shall be referred to the appropriate specialist.

The Contractor shall provide or arrange for the following vision services:

- Diagnosis and treatment within the PCP's scope of practice
- Vision screening in accordance with EPSDT periodicity schedule
- Referral for follow-up to Optometrist or Ophthalmologist, if indicated
- Provide assistance in obtaining prescriptive lenses, directly or linking with other community resources.

The Contractor shall provide or arrange for the following hearing services:

- Diagnosis and treatment within the PCP's scope of practice.
- Hearing screening to include history, risk factors, and physical examination;

- Referral for follow-up, if indicated; and
- Provide assistance in obtaining hearing aids, either directly or by linking with other community resources.

Physical examinations performed to satisfy the demands of outside public or private agencies such as the following are not covered services:

- Qualification for insurance.
- Pilots' examinations (FAA).
- Disability certification for the purpose of establishing any kind of periodic payments.
- Evaluation for establishing third party liability.

When specialty treatment or a service beyond the capacity of the Contractor is required, the Contractor shall refer the client to an appropriate provider and assist in negotiating with the provider for a reasonable and/or reduced charge for the service. Some children with special health care needs may be eligible for diagnostic and treatment services under the Children's Rehabilitative Services Program of ADHS.

C. DIAGNOSTIC LABORATORY and DIAGNOSTIC IMAGING SERVICES

Diagnostic laboratory, radiology and imaging services shall be provided by the Contractor or through an established referral process when necessary to diagnose and complete a treatment. Such services must be medically necessary and prescribed by either a PCP or dentist. Laboratory, radiology and imaging services may be for screening, testing, diagnosis, prevention, treatment or assessment of a medical condition. Covered services include such procedures as CAT scans, MRI's, mammograms, colposcopies, and other diagnostic procedures that are required for the PCP or dentist to determine whether the client may continue treatment within the provider's scope of practice or whether the client requires referral to a specialty provider. Such procedures as simple biopsies are covered if a PCP in a primary care service setting can perform the procedures.

A co-pay or sliding fee may be charged to patients with family incomes above 100% of the Federal Poverty Level Guidelines.

D. PHARMACY SERVICES

Pharmacy services shall be provided by the Contractor or through an established referral process when necessary to complete treatment. Prescription drugs shall be prescribed by a primary care provider or dentist and provided by a licensed pharmacy. Primary care providers or dentists may dispense medications only in accordance with their professional licensure.

Nonprescription drugs and over-the-counter medicines are not covered, except when nonprescription drugs are appropriate, available and less costly than the prescription drug being considered. Generic drugs and samples shall be used whenever possible. When sample medications are used or dispensed, the Contractor shall have in place the policies and procedures for the control and dispensing of sample medications that include:

1. Appropriate selection of sample medications that will be kept within the facility, including the acceptability and process for the use of non-formulary sample medications.

2. Proper storage, control and accountability of sample medications.

3. Proper labeling and dispensing of sample medications, including documentation of dispensing and maintaining an inventory.

4. Having an effective recall mechanism for sample medications.

5. Monitoring the effects of sample medications in patients.

Processes for sample medications are expected to be consistent with those that the Contractor uses for the same category of regular, non-sample medications.

A formulary or drug list shall be adopted by the contractor for use in conjunction with PCP services. A copy of the formulary or drug list should be submitted to ADHS at contract renewal and as it is changed or updated. This formulary or drug list should be established with input from the primary care providers and must include those medications necessary to address typical patient treatment needs. A mechanism should be established for a provider to request a non-formulary drug should the need arise.

A co-pay, dispensing fee or sliding fee may be charged to patients with family incomes above 100% of the Federal Poverty Level Guidelines.

Contractors with direct pharmacy operations must take advantage of discounted acquisition cost programs (i.e., "340B"). Contractors who subcontract for pharmacy services shall submit an up-to-date copy of the vendor contract to ADHS at the time of contract award or renewal. As appropriate, the Contractor shall assist patients with utilization of the various manufacturer-sponsored "Prescription Drug Assistance Programs." Except in unusual circumstances, no limitations or "cap" shall be imposed on the medications necessary for treatment. Any such limitation must be approved by the ADHS.

E. HEALTH EDUCATION AND HEALTH PROMOTION

Health education (e.g., patient counseling and group workshops) and health promotion (e.g., health fairs and public service announcements) activities shall be conducted in both the clinical setting and within the community. Information provided shall be age-appropriate, client-centered and culturally-competent. Priority shall be given to addressing the lifestyle behaviors most associated with the development of premature and preventable chronic disease and morbidity - tobacco use, poor nutrition and lack of exercise. However, as dictated by the community need, other prevention programs may be conducted (e.g., substance abuse prevention, domestic violence prevention, etc.).

F. REFERRAL, TRACKING and FOLLOW-UP SERVICES

Contractors shall attempt to assist individuals in obtaining needed care through referral or other arrangements when specialty or other health services not covered by this program are required. Contractors are to ensure that clients understand their payment responsibility for uncovered services. Referral, tracking and follow-up services shall include:

1. Identifying community resources for non-covered services that may include medical services, financial assistance, behavioral health services, social services, and nutritional services. The Contractor shall determine referral procedures for each service and identify those services available at low or no cost.

2. Coordinating referrals for covered and non-covered services to ensure services are rendered. For example, eye care provided by an Optometrist or Ophthalmologist.

3. Conducting follow-up and obtaining records of services provided by other primary care providers, specialty providers and/or hospitals.

4. Implementing a procedure to notify clients of appointments and periodic health screenings.

G. WELL-WOMAN HEALTHCHECK SERVICES

Women in need of mammograms and/or pap smears, who meet the eligibility criteria for the Well-Woman Healthcheck Program (WWHP) (see Appendix J), shall be screened under the WWHP. The PCP shall be considered the payor of last resort for these screenings. It should also be noted that in order to be eligible for breast and/or cervical cancer treatment services available through the WWHP, women must be screened and diagnosed while they are enrolled in the program. Women cannot be referred to WWHP for treatment after receiving a diagnosis under the PCP or while under the care of another provider.

H. PRENATAL CARE SERVICES

Prenatal care is health care provided during pregnancy and comprises three major components: 1) Early and continuous risk assessment; 2) Health promotion; and 3) Medical monitoring, intervention and follow-up. Prenatal care services include but are not limited to identification of pregnancy, medically necessary services for the maintenance of the pregnancy, and treatment of pregnancy-related conditions. The Contractor shall:

1. Adhere to the standards of care of the American College of Obstetrics and Gynecology, including the use of a standardized medical risk assessment tool and ongoing risk assessment during the pregnancy.

2. Educate clients about healthy behaviors during pregnancy including proper nutrition; the physiology of pregnancy; the process of labor and delivery; breast-feeding and other infant care information.

3. Refer clients to non-medical assistance such as WIC and notify women that, in the event they lose their eligibility for this program, they may contact the Department of Health Services Hot Line for referrals to low or no-cost services, and other appropriate community resources.

4. Maintain a complete medical record documenting all aspects of prenatal care.

5. Make provisions for pregnant clients to obtain initial prenatal care appointments within the following time frame:

    a. First trimester: within two (2) weeks of a request for an appointment,
    b. Second trimester: within one (1) week of a request for an appointment,
    c. Third trimester: within three (3) days of a request for an appointment, and
    d. High-risk pregnancy care must be initiated within three (3) days of the client's request, or immediately if an emergency exists.

6. Make provisions for pregnant clients to obtain return visits within the following timeframes:

    a. Every four (4) weeks for the first 28 weeks,
    b. Every 2-3 weeks until 36 weeks,
    c. Weekly: 37 weeks until delivery, and
    d. High-risk clients shall have a return visit scheduled appropriate to their individual needs.

7. Arrange for a postnatal follow-up. These services shall include family planning counseling and well-baby care.

Prenatal care services may either be provided in-house by the Contractor or through a sub-contract or referral arrangement. Either the Contractor or the prenatal service provider shall assist the client in making arrangements for labor and delivery services. Contractors shall also provide postpartum care. ADHS funded primary care programs do not cover labor and delivery services.

I. FAMILY PLANNING SERVICES

Family planning services are covered when provided by physicians or practitioners to clients who voluntarily choose to delay or prevent pregnancy. Family planning services include medical, pharmacological and laboratory services described in this manual. Family planning services also include the provision of accurate information and counseling to allow eligible clients to make informed decisions in choosing a specific family planning method.

Contractors shall insure that family planning services are provided in a manner free from coercion or mental pressure; available and easily accessible to clients; provided in a manner which assures continuity and confidentiality; provided by, or under the direction of, a qualified physician or practitioner; and documented in the medical record. In addition, documentation should be recorded that each client of reproductive age was notified verbally or in writing of the availability of family planning.

Covered family planning services include:

1. Contraceptive counseling, medication, and supplies, including, but not limited to: oral (birth control pills) and injectable contraceptives (i.e. Depo Provera), intrauterine devices (insertion and removal), diaphragms, condoms, spermicides.

2. Associated medical and laboratory examinations including, but not limited to, physical exams; pelvic exams; pap smears; pregnancy testing; and chlamydia screening, testing and treatment (per CDC Guidelines).

3. Natural family planning education or referral to qualified health professionals.

4. Postcoital emergency oral contraception within 72 hours after unprotected sexual intercourse.

Pregnant women planning to carry their pregnancy to term must be offered information and referral to prenatal care. Women requesting information on options for the management of an unintended pregnancy must be given non-directive counseling on alternative courses of action and referral upon request.

Contractors are expected to make basic infertility services available to clients who request such service. Services include: initial interview, physical examination, appropriate laboratory testing, education, counseling, and appropriate referral.

ADHS funded primary care programs shall not be used to provide abortion services, tubal ligations or hysterectomies to clients as a method of family planning.

J. PREVENTIVE DENTAL SERVICES

The intent of the PCP is to establish a "medical home" for clients seeking services. Therefore, clients may not utilize the PCP for obtaining dental services only.

Dental care is a part of primary care services. Primary and secondary prevention services including preventive and basic dental treatment provide a framework for delivering dental care to eligible clients. The Contractor shall directly provide preventive and basic dental treatment services or arrange for the services by developing linkages and/or formal agreements for referrals to existing dental care systems. Therefore, services may be provided in a private dental practice, community dental clinic or other community-based settings. PCP covered diagnostic, preventive and restorative dental services are listed in Appendix I of this manual. The Contractor shall provide the following services as described below:

1. Health Promotion:

   Promote standard preventive measures in dental health such as water fluoridation, fluoride supplementation, fluoride mouthrinse and dental sealants.

2. Oral Assessment/Examination:

   a. Obtain and review medical history, current medical status, dental history and current dental status;
   b. Provide assessment of oral health status and needs of the client;
   c. Provide oral examination, prescribe/deliver appropriate diagnostic tests including radiographs, record findings, make appropriate diagnosis of oral and dental health problems, treatment and meet general patient management needs;
   d. Develop and record a treatment plan with alternatives when appropriate.

3. Primary Preventive Dental Services:

   a. Provide prevention services. Prevention should focus on maintaining and preserving the oral health of the client through assessment, screening and various dental preventive techniques such as the use of fluorides, oral prophylaxis/ cleaning, and dental sealants.

b. Participation in school-based dental sealant programs is encouraged in order to increase the proportion of children receiving preventive dental services.

4. Secondary Preventive Dental Services:

a. Provide basic treatment services. Basic dental treatment services should be targeted to prevent tooth decay and gum disease as well as to restore hard and soft oral/dental tissue to a functional use for an individual.

b. Provide basic restorative treatment (e.g., fillings and stainless steel/resin crowns).

c. Provide emergency treatment for oral/dental pain and infection (e.g., toothache and abscess).

d. Provide basic oral surgery (e.g., simple extractions, incision and drainage and biopsy).

5. Adjunctive Services:

a. Provide necessary drugs or medications;
b. Provide follow-up services when necessary;
c. Provide patient education including discussion of dental problems, treatment needs, treatment plan and home care;
d. Provide appropriate referrals to specialists; and
e. Maintain and/or ensure subcontractors maintain standardized and organized dental patient records.

K. TRANSPORTATION SERVICES

The Contractor shall arrange transportation for clients who require such assistance and who would not otherwise receive provider-ordered, medically necessary primary care. Free transportation services are to be arranged whenever possible. The Contractor is responsible for arranging or paying for non-emergency medically necessary ground transportation for clients to and from a covered medical service when a client is unable to provide/secure/pay for transportation. Such transportation may be covered if the following requirements are met:

1. The client has no form of transportation to an appointment for a covered service;

2. Covered services are not available where the client is; and

3. The transportation is for covered services only.

Contractors shall keep a record of any charges and/or expenditures for transportation.

L. SAME-DAY SERVICES

The Contractor shall provide for same-day care and acute care treatment to clients when they exhibit an illness or condition that requires immediate attention to prevent progression to an emergent status. These services shall include those that are customarily provided by primary care providers in an outpatient/ambulatory setting.

M. ON-SITE EMERGENCIES

The Contractor shall be prepared to provide emergency stabilization services to clients who experience an emergent medical condition on site. This means that the Contractor shall insure that appropriate staff are trained in First Aid procedures and certified in Basic Cardiac Life Support (BCLS); Advanced Cardiac Life Support (ACLS) skills are preferred. One staff person should call 911 or the appropriate phone number to activate the local emergency medical services (EMS) system while the trained staff are stabilizing the client.

N. TWENTY-FOUR HOUR COVERAGE

The Contractor shall provide services a minimum of five (5) days per week, 8 hours per day, excluding holidays.

The Contractor shall provide after hours coverage, 24 hours a day, seven days week. This may be accomplished through a telephone triage system. Phone consultation and referral shall be available at all times.

O. BEHAVIORAL HEALTH SERVICES

The Contractor shall provide services to clients with behavioral health needs that may be addressed in the primary care setting. If the screening identifies the need for additional behavioral health services, the Contractor shall assist the client with referral to other community resources as appropriate.

PART IV: ADDITIONAL PROGRAM REQUIREMENTS and STANDARDS

A. QUALITY ASSURANCE

The Contractor shall have a system of Quality Assurance that is based on established clinical protocols and standard written procedures that are approved by the appropriate medical or clinical director and reviewed at least annually. The Quality Assurance system shall also include appropriate protocols and written procedures for non-clinical staff. Quality Assurance meetings shall be held at least quarterly. The issues, findings, decisions and corrective actions related to Quality Assurance oversight shall be documented. Contractors providing school-based services are encouraged to use the Quality Assessment and Improvement format developed by the ADHS Office of Women and Children's Health.

The Contractor shall post or provide copies of the "Patient's Bill of Rights" outlining the expectations regarding services and practices within the facility. The mechanism for addressing patient complaints must be in place. This information shall be in English and Spanish and shall include the name and phone number of the individual responsible for receiving and hearing any complaints about the quality of services rendered by the Contractor. The Contractor shall conduct patient satisfaction surveys on an annual basis. The findings shall be recorded and used to foster improved patient care.

B. LICENSURE/CERTIFICATION REQUIREMENTS

The Contractor shall obtain and/or maintain all licenses, accreditations and/or certifications required to conduct business and provide contracted services in the State of Arizona. Licenses, accreditations and/or certifications include, but are not limited to:

1. Personnel: The Contractor shall ensure its personnel are duly licensed, certified or registered in their respective field by the appropriate Arizona agency.

2. Facility: The Contractor shall ensure all service delivery facilities are duly licensed by ADHS and/or any other applicable regulatory agency.

3. Laboratory: The Contractor shall ensure all laboratory services are provided in a Clinical Laboratory Improvement Act (CLIA) certified laboratory or in a laboratory with a CLIA Certificate of Waiver or Joint Commission on Accreditation of Healthcare Organizations (JCAHO) accreditation.

4. Subcontracts: The Contractor shall ensure all subcontractors' personnel and facilities are duly licensed, certified or registered by the appropriate Arizona agency and/or any other applicable regulatory agency. All subcontracting relationships entered into by the Contractor shall be reported to ADHS.

C. NETWORKING/BEST PRACTICES/HEALTH DISPARITIES

Contractors are expected to participate in networking opportunities with other Primary Care Program contractors, County Health Departments, local Emergency Medical Service providers, and others as indicated.

Efforts to develop and implement "best practices" are encouraged. Best practices are those research-based strategies, activities or methodologies that have been proven effective, through evaluation and substantial quantitative data, in obtaining positive outcomes over a period of time and whose replication supports generalization of these outcomes across populations. Best practices and "lessons learned" shall be shared at quarterly contractors' meetings and in quarterly reports to ADHS.

Special attention is essential to addressing health disparities among racial and ethnic minorities. Contractors will foster cultural and linguistic competence within the healthcare system.

D. STANDARDS OF CARE

The Contractor shall adhere to generally accepted standards of care. Specific reference is made to the standards of care of the American College of Obstetrics and Gynecology for prenatal Care.

Another example of this expectation is the "Standards of Medical Care in Diabetes" adopted by the American Diabetes Association. The current standards may be found in the journal *Diabetes Care.*

PART V: FINANCIAL REQUIREMENTS

A. ACCOUNTABILITY

The Contractor shall follow the practices and standards specified in and required by the Accounting and Auditing Procedures Manual for ADHS in the management of contract funds. ADHS reserves the right to audit the records of a Contractor to determine that the funds paid to the Contractor were for services specified in the contract.

B. BILLING/PAYMENT METHOD

The Contractor shall submit an "invoice" by using the ADHS Contractor Expenditure Report (CER) as exhibited in Appendix H. The CER submitted to ADHS shall have an original signature of the person authorized by the Contractor to sign the invoice. Upon receipt of the CER, and receipt and acceptance of the requisite eligibility and encounter data files, the CER shall be processed by HSD and payment made to the Contractor by the ADHS accounting office within thirty (30) days.

The Contractor shall submit encounter and eligibility data to HSD within twenty (20) days following the month in which the services were provided. See Appendix K for data submission requirements.

Should there be errors in the eligibility and/or encounter data originally submitted, the Contractor may submit a second CER for the month after these errors have been corrected. A resubmitted CER must be received by ADHS within ninety (90) days following the month in which the encounters occurred. See Appendix K for complete instructions on data corrections and resubmissions.

C. FINANCIAL MANAGEMENT

ADHS reserves the right to maximize the utilization of primary care funds by making adjustments to a contractor's purchase order. An adjustment to the budgeted amount detailed on the purchase order has the effect of changing a contractor's award amount for that fiscal year.

PART VI. REPORTING REQUIREMENTS

All notices, correspondence, data, and quarterly progress reports shall be submitted to the Office of Health Systems Development at the following address:

Arizona Department of Health Services
Office of Health Systems Development
1740 W. Adams, Room 410
Phoenix, Arizona 85007

Quarterly Progress Reports shall include a narrative summary of program activities and other pertinent information related to the Scope of Work. All Quarterly Progress Reports are to be submitted in the format prescribed in Appendix G. Quarterly Progress Reports shall be submitted to HSD within thirty (30) days after the end of each state fiscal year quarter for which the report is written.

The Contractor shall submit all required reports, including any reports mandated by legislation and/or requested by the ADHS. The Contractor is expected to notify HSD prior to the deadline of any difficulties experienced by the Contractor in complying with the reporting requirements.

All encounter and eligibility data are to be submitted to HSD via the Internet at the URL www.azdhs.gov. The specific e-mail address of the HSD staff person responsible for the receipt of the data shall be made known to the Contractor as required. All data shall be transmitted in zipped files that are password protected. The contractor shall comply with all HIPPA requirements.

APPENDIX A
DEFINITIONS

- ADHS means the Arizona Department of Health Services.
- AHCCCS means the Arizona Health Care Cost Containment System as defined by A.R.S. § 36-2903, et seq.
- AzMUA means Arizona Medically Underserved Area as defined by A.R.S. § 36-2352.
- "CER" means the Contractor's Expenditure Report.
- "Client" means a person who has been determined eligible for Primary Care Program services.
- "Contract Year (CY)" means the state fiscal year (July 1 through June 30).
- "Contractor" means a person, organization or entity agreeing through a direct contracting relationship with ADHS to provide those goods and services specified by contract in conformance with the requirements of such contract.
- "Counseling" means a process of a medical and/or non-medical nature that assists persons in dealing with a wide range of person/interpersonal, situational and functional problems. These services may be delivered over varying lengths of time and may be provided on a face-to-face basis to individuals, families or small groups.
- "Covered Services" means those required services as specified in this Manual.
- "Days" means Calendar days unless otherwise specified.
- "Eligibility Determination" means a process of determining, through the production of documents establishing the client's eligibility, whether a person meets the eligibility qualifications as specified by the Primary Care Program.
- "Encounter" for purposes of the Primary Care Program (PCP), means a contact between an eligible individual and the health care facility or system for a health service or set of services related to one or more medical conditions, as documented by either a HCFA 1500 or a UB-92. An encounter must be documented in the patient's medical record.
- "Family" means a family unit consisting of:
  1. A married couple and children of either one or both;
  2. An unmarried couple with a common child and other children of either or both;
  3. A single parent and his or her children;
  4. A child under the age of 19 who does not live with a parent;

5. A child or an unborn of a child is included in its parents' household indicated above;
6. Grandparent or other non-parent relatives of a child are not considered part of the household. A child living with a grandparent or other relative instead of a parent will be its own household, and;
7. A child is a person that is under the age of nineteen (19).

- "Federal Poverty Level Guidelines" (FPL) means those guidelines issued annually by the federal Department of Health and Human Services and announced in the Federal Register, to be used to determine payment amounts for those uninsured Arizona residents who are eligible for the Primary Care Program. Two hundred percent of poverty is determined by doubling the figure for one hundred percent of poverty. The poverty information may be accessed at: http://aspe.os.dhhs.gov/poverty.

2004 HHS Federal Poverty Guidelines

Family Size	100% FPL	200% FPL
1	$ 9,310.00	$18,620.00
2	$12,490.00	$24,980.00
3	$15,670.00	$31,340.00
4	$18,850.00	$37,700.00
5	$22,030.00	$44,060.00
6	$25,210.00	$50,420.00
7	$28,390.00	$56,780.00
8	$31,570.00	$63,140.00

For family units with more than 8 members, add $3,180 for each additional member, and double that number to obtain the 200% FPL. (The same increment applies to smaller family sizes also, as can be seen in the figures above.)

- "HIPAA" means Health Insurance Portability and Accountability Act.

- "HSD" means Health Systems Development, the unit within the ADHS that is responsible for administration of the PCP.

- "Medical Record" means a confidential written record of all the covered services a client receives and client contacts that is maintained for each enrolled client.

- "Medicare" means the federal program authorized by Title XVIII of the Social Security Act, as amended.
- "Notice" means a notice of the availability of ADHS - funded Primary Care Services,

required to be published by a Contractor in a local newspaper of general circulation, and a written notice of the availability of these services, including eligibility requirements, posted in public areas of the Contractor's service site.

- "Nurse practitioner" means a registered nurse certified by the Arizona State Board of Nursing to function in the extended role pursuant to A.R.S. Title 32, Chapter 15.

- "Physician" means a person licensed pursuant to A.R.S. Title 32, Chapter 13 or 17, and shall include nonresident practitioners holding area permits pursuant to A.R.S. 32-1426.01 or 32-1823.02, or a person practicing as a federally employed physician.

- "Physician assistant" means any person certified by the Joint Board of Medical Examiners and Osteopathic Examiners in Medicine and Surgery as a physician's assistant.

- "Primary care physician" means a non-federally employed doctor of medicine (M.D.) or doctor of osteopathy (D.O.) who does not practice full-time in a State correctional institution and who practices principally in one of the four primary care specialties: general or family practice, general internal medicine, pediatrics, obstetrics and gynecology.

- "Primary care provider" (PCP) means a primary care physician, certified nurse practitioner, a physician's assistant, a certified nurse midwife, or a licensed midwife.

- "Primary care services" means integrated, accessible health care provided by licensed physicians, nurse practitioners, certified nurse midwives and/or physician assistants who are accountable for addressing a large majority of personal health care needs by developing a sustained partnership with the patient, and practicing in the context of family, culture, and community.

- “Project Officer” means the person within the Office of Health Systems Development who has been assigned primary responsibility for the management and oversight of a particular contract.

- "Referral" means the concept of linking clients in need of particular services to those services, including telling the client the reason for the referral and assisting them to access the service. It also includes contacting the receiving agency, sending all necessary information and documentation to the receiving agency, and following up with the receiving agency.

- "School Based Clinics/Centers" means school sites where medical and/or social services are provided to the students of that school.

- "Screening" means the use of valid, quick, simple, cost effective procedures to determine

if clients have a condition, illness, or injury that requires further definitive study and treatment.

- "Sliding Fee Schedule/Sliding Fee Scale" (SFS) means the discount to charges that a provider offers to patients who are uninsured and at a certain point on the Federal Poverty Level.

- "SPID or Standardized Patient Identification" means, for purposes of the Primary Care Program, a specific number that is used to identify and track eligible clients who receive covered services from a Contractor. The number consists of the person's first and last initials, six figure birth date, and the letter designating Male or Female. If there are multiple identical SPIDs, then a leading numerical modifier is added. Example: The SPID for James Doe, birthdate October 15, 1966 is JD101566M. If James Doe is a twin to John Doe, their SPIDs would be: 1JD101566M and 2JD101566M.

- "Subcontract" means an agreement entered into by a Contractor with a provider of health care services who agrees to furnish covered services to clients related to fulfilling the Contractor's obligations to ADHS under the terms of this contract.

- "Treatment" means health care or services to prevent or ameliorate a condition, illness, or injury or prevent or correct abnormalities detected by screening or diagnostic procedures.

- "Uncompensated Care" means services provided by primary care providers for which no payment is received from the patient or from third party payers.

- "Uninsured" means, for the purposes of the ADHS - funded Primary Care Program, any individual who does not have contractual medical policy coverage which binds the insurer to indemnify that individual for the allowable cost of covered goods and services provided to him/her by an authorized source. Members of federally recognized Native American Tribes eligible to receive services made available either directly or through contract by the Indian Health Service of the United States Public Health Service are not considered "insured" for the purpose of determining their eligibility to receive services under the Primary Care Program.

- "User" means an individual who has been determined eligible for Primary Care Program services and receives health services from a PCP Contractor during the contract term.

- "Visit," for purposes of the Primary Care Program (PCP), means one or more encounters involving face-to-face contact between an eligible individual and a medical provider (e.g., MD, DO, FNP, PA) or a dental provider (e.g., DDS, DMD) for covered health services authorized by a PCP Contractor. The visit is for the purpose of receiving Primary Care Services or referrals to appropriate services. A visit must be documented in the medical record. A visit does not consist of a client stopping by the facility to pick up medications or dropping off a specimen at the laboratory.

APPENDIX B

ARTICLE 1. SLIDING FEE SCHEDULE

R9-2-101. Approval of Sliding-fee Schedule

A. For purposes of this Section, "sliding-fee schedule" means a document that sets forth the relationship between an individual's income and family size and states the percentage of the charges for health care services provided pursuant to A.R.S. § 36-2907.06 for which the individual will be responsible.

B. At least 30 calendar days before implementation of the sliding-fee schedule, a qualifying community health center shall submit an application for approval of the schedule to the Department of Health Services. Submission occurs at the time the Department receives a correctly completed application. The application shall contain:

1. The qualifying community health center's name and street address including city, state, and zip code;
2. The qualifying community health center's telephone number; and
3. The name of the qualifying community health center's administrator.

C. The Department of Health Services shall notify the qualifying community health center in writing of approval or disapproval within 20 calendar days of submission of application. A sliding-fee schedule shall not be implemented without approval. If an application is disapproved, the Department shall set forth the reasons for the disapproval in the written notice. Within 15 calendar days of receiving a written disapproval, a qualifying community health center may file a written request for a hearing with the Department to appeal the disapproval.

D. The sliding fee schedule shall cover income levels from 0 to at least 200% of the federal poverty level.

E. A qualifying community health center shall not deny health care services to an individual eligible for health care services pursuant to A.R.S. § 36-2097.06 because the individual is unable to pay for the health care services.

F. A qualifying community health center shall apply a 100% discount for an eligible individual with an income at or below 100% of the federal poverty level. A qualifying community health center may establish a minimum fee for administrative processing costs for all eligible individuals without regard to income level. A qualifying community health center shall charge the greater of either the administrative fee or the amount of the charges for services for which an eligible individual is determined to be responsible according to the sliding-fee schedule.

G. An individual covered by a sliding fee schedule shall not be responsible for an amount greater than the amount determined by applying the sliding fee schedule to the lowest contracted charge for each service received. The lowest contracted charge for a service is determined by reference to contracts covering that service, in effect at the time that the service is rendered, between the qualifying community health center and any payor, subject to limitations of federal and state laws and regulations.

H. The qualifying community health center shall post a notice at or near the main entrance and in each waiting room. The notice shall be in both English and Spanish and shall contain the following information:

1. The qualifying community health center provides primary care services to uninsured Arizona residents with family incomes of 200% or less of the federal poverty guidelines and who meet the eligibility requirements of the Tobacco Tax Primary Care Program, A.R.S. § 36-2907.06.

2. The name of the individual or unit within the qualifying community health center that interested persons may contact to have an eligibility determination interview for the Tobacco Tax Primary Care Program.

3. The qualifying community health center's use of an Arizona Department of Health Services-approved sliding fee schedule to determine the payment responsibility of eligible persons.

4. The name and phone number of the qualifying community health center's staff member responsible for receiving and hearing any complaints from eligible persons regarding their payment responsibility for Tobacco Tax Primary Care Program services.

I. The qualifying community health center shall keep a log and file of all complaints dealing with payment responsibility under the sliding fee schedule. The log and file shall indicate the name and address of the eligible person, the nature of the complaint, the date the complaint was received, the date the decision was rendered, and the date the decision letter was sent to the eligible person. The qualifying community health center shall retain the log and file for 12 months after the decision letter is sent.

APPENDIX C

ESSENTIAL ATTRIBUTES OF A PRIMARY CARE SYSTEM

PRIMARY CARE SYSTEM:

It is expected that a Contractor is or shall become a part of a "Primary Care System" (PCS). A fully developed Primary Care System exhibits the essential attributes described below. A developing primary care program may lack certain of the essential attributes during its initial developmental stages. In such cases, the Contractor will be expected to carry out a developmental process that will adequately exhibit the necessary attributes. It is expected that the Contractor's service delivery system should satisfactorily manifest the eight essential attributes. For smaller or isolated providers, the attributes of "comprehensive" and "coordinated" may be achievable only when the provider actually becomes a part of a PCS.

In its broadest sense, PRIMARY CARE is personal health care delivered in the context of family, culture and community, and whose range of services meets all but the most specialized health needs of the individuals and families being served. Primary care is the integration of services that promote and preserve health; prevent disease, injury and dysfunction; and, provides a regular source of ambulatory care for acute and chronic illnesses and disabilities. Primary care is the usual and most desirable entry point into the larger system of care, and its providers ensure the coordination of primary care services with other health and human services. Primary care incorporates community needs, risks, strengths, resources and cultures into clinical practice. The primary care provider shares with the affected individual and family, an ongoing responsibility for care.

A fully developed PRIMARY CARE SYSTEM actualizes the above broad definition by ensuring that both its services and overall organization have the following essential attributes:

- COMMUNITY BASED
- COMPREHENSIVE
- FAMILY CENTERED
- CONTINUOUS
- COORDINATED
- CULTURALLY COMPETENT
- ACCESSIBLE
- ACCOUNTABLE

COMMUNITY BASED means that the system:

1. Serves a defined "area" that can be described in at least geographic, demographic and special target population terms; can identify that area's major personal and population based health problems; creates or modifies primary care services to ensure

responsiveness to the identified major health problems; and, periodically assesses the impact of its services.

2. Establishes and maintains one or more conveniently located service delivery sites within its geographically defined territory.

3. Establishes and, within the limits of its available resources, maintains a policy of "need based access" to available services. ("Need based access" means access determined solely by an individual's medical need for primary care services, and without regard to other factors such as his/her ability to pay, age, sex, occupational category, race/ethnicity, etc.)

4. To the extent possible, gives employment priority to residents of the area being or to be served.

5. Routinely cooperates with and participates in related public health and human service activities, and

6. Establishes and maintains one or more mechanisms for ensuring that the views of service users and area residents are incorporated into decisions involving the system's policies, priorities, plans and operations. Appropriate mechanisms include, for example, the development of a community governing or advisory board, regular periodic public meetings, the regular periodic use of system satisfaction surveys, and the solicitation of written support from service users and key community members.

COMPREHENSIVE means that the system:

1. Provides a continuum of developmentally essential personal health services that promote and preserve health, prevent disease, injury and dysfunction, as well as providing care for acute and chronic illnesses and disabilities. The system also identifies and addresses the population-based needs of the community and, in so doing, recognizes the many dimensions of health beyond its physical components, such as the social and environmental. A comprehensive primary care system directly provides the general ambulatory care services needed by a substantial proportion of the individuals and families in its community, and develops clearly defined referral arrangements for the more uncommon and specialized needs.

2. For the Primary Care Program programs, ensures that treatments, procedures or visits must have proven effectiveness, be appropriately indicated and must meet primary care's essential attribute of Comprehensiveness. The treatment plan must be based upon the goal of and potential to preserve or improve the functioning of the primary care patient. This plan may therefore include care of a patient in the inpatient or skilled nursing setting. In addition, treating a patient in an emergency room setting may also be appropriate when less costly outpatient setting modalities have been exhausted and/or doing otherwise would adversely affect the patient's medical outcome.

FAMILY CENTERED means the system:

1. Recognizes that the family is typically an essential participant in the appropriate assessment and treatment of its members, and routinely encourages such participation.

2. Understands and accepts variation in family structure and function and, to the extent possible, develops service availability, access and other policies which account for such variation. Finally, it means the system understands the actual/potential impact of a family member's health, illness, disability or injury on the overall structure, functioning and dynamics of the family and, to the extent possible, attempts to mitigate any negative impact.

CONTINUOUS means the system:

1. Is a family or individual's regular, ongoing source of care over time, regardless of the presence or absence of disease or injury. It also means that there is a widely understood system of after-hours coverage that allows the individual or family to easily access care outside of established operating times.

2. Establishes a "health care home" for each individual and family, and has as its essential ingredients a client-provider relationship based on knowledge and trust, and a unified client record of all health care events, needs and services provided.

3. Supports and maintains a relationship between the Primary Care Provider and his/her patient in all clinical settings as medically necessary. Medical necessity is evidenced when the treatment, diagnostic or therapeutic procedure or visit rendered by a primary care provider is done to prevent or treat disease or disability, or to allay the progression of adverse health conditions. In addition, such treatments, procedures or visits are required to complete the primary care treatment plan.

   Treatments, procedures or visits that are cosmetic, elective, specifically proscribed by the Primary Care Program (e.g.: deliveries), or in which the primary care provider relinquishes principal care to a non-primary care provider (specialist), do not meet the definition of medical necessity.

COORDINATED means the system:

1. Links health care events, needs and services through the establishment of mechanisms for the transfer of relevant information, its recording in the unified client record, and its incorporation into the health care plan for that individual or family.

2. Has the responsibility and obligation to ensure the timely transfer of information among its various elements and outside the system. Among other things, coordination ensures that the more narrowly focused perspectives of medical specialists, as well as the non-

medically focused perspectives of other human service providers, are combined into a more holistic view of client needs.

CULTURALLY COMPETENT means that in the provision of its services, the primary care system:

1. Recognizes and accounts for the varying cultural characteristics and sensitivities among different groups in its community.

2. Ensures, to the extent possible, that its services are acceptable to all groups of people in the community who are distinguished by common values, language, worldview, heritage, institutional affiliation, or beliefs about health and disease.

3. Creates mechanisms to solicit the views of these groups and incorporates those views into decisions regarding policies, priorities, plans and operations related to the delivery of services.

ACCESSIBLE means the system:

1. Actively facilitates the individual or family's entry into care by ensuring that needed services are available to all members of the community, conveniently located in terms of geography and transportation, affordable, culturally appropriate; and, provided without regard to factors other than need.

2. Pays special attention to issues such as the times at which services are available, user acceptance, and the special needs of persons with disabilities.

ACCOUNTABLE means the system:

1. Has established implementing standards for each of the above-defined attributes, monitors compliance with those standards, and ensures timely remediation in instances of significant non-compliance.

2. Ensures, for its clinical services, that they are delivered in accordance with current best clinical practices.

APPENDIX D

CLIENT ELIGIBILITY PROCEDURES

A. The Contractor shall have on file for audit purposes, a signed intake/eligibility form (see Appendix E for preferred format) for each client that receives ADHS-funded services. The form shall contain all of the following elements:

1. Name of the client.
2. Birth date
3. Standardized Patient Identification (SPID)
4. Marital status
5. Race: A = Asian B = Black H = Hispanic I = Native American
   P = Pacific Islander W = White O = Other
6. Address, including zip code.
7. Dated signature of client. If the client is a child, the parent/legal guardian shall sign the form. The parent/legal guardian signature shall serve as consent for treatment of minor children, with appropriate wording on the form.
8. Residency: Identify how residency is established.
9. Medical insurance status: Confirm method used to document status.
10. Client/family income.

    a. Document total gross annual family income, source of income, and attach a copy of the document, e.g., paycheck stub, or signed, dated waiver of verification. Gross income is calculated by multiplying the gross pay indicated on the paycheck stub by 52 when payment is weekly; by 26 when payment is bi-weekly, and by 12 when payment is monthly.

    b. Determine family size. "Family" means a family unit consisting of:
       i. A single parent and his or her children;
       ii. A married couple and children of either one or both;
       iii. An unmarried couple with a common child and other children of either or both;
       iv. A child under the age of 19 who does not live with a parent;
       v. A child or an unborn of a child is included in its parents' household indicated above;
       vi. Grandparent or other non-parent relatives of a child are not considered part of the household. A child living with a grandparent or other relative instead of a parent will be its own household, and;
       vii. A child is a person that is under the age of nineteen (19).

NOTE: The current Sliding Fee Schedule rule (Appendix C) contains relevant definitions of "Family" that may assist in family size eligibility determination.

c. Document where the client falls on the percent of poverty.

11. Eligibility re-determination. All eligible persons shall have their eligibility re-determined every twelve months, or more frequently if their household size, insurance status or financial situation changes. Use a new registration form with up-dated information, when changes occur. Contractors are encouraged to verify continued eligibility of a client at each primary care provider visit and retain copies of all eligibility determination forms.

B. Eligibility Procedures

The purpose of these procedures is to describe the means by which eligibility determination may be done, including the documents to be collected and examined. All forms and copies of documents used to determine the client's eligibility shall be kept on file by the Contractor for audit purposes.

1. State Residency. Indicate on the client's eligibility form how residency was determined. The client may submit any of the following types of documents:

   a. Rent, mortgage, or lease receipt in the clients name showing the residential address;
   b. Statement from a non-relative landlord giving the name and address of both parties;
   c. Arizona motor vehicle registration (not driver's license);
   d. Utility bill or U.S. Post Office records showing the client's name and address (must indicate a street address, not a P.O. box); or
   e. Pay stub with client's name and home address imprinted on it.

2. Medical Insurance. The client may declare that he/she/family is uninsured. In addition, the client must be screened for AHCCCS/KidsCare and Medicare eligibility, as detailed in Sections 4 and 5 below.

3. Income: percent of poverty. The client may declare his/her income for the first visit; however, the client must bring in any one of the following means of verification within the next month. This requirement is waived for clients who are Migrant/Seasonal Farm workers or others who cannot obtain verification. A signed and dated waiver of verification must be included in the application. The client's/family's total gross income (consider both earned, unearned income and overtime) is compared to the Federal Poverty Guidelines. Paycheck stubs, employer's statements, or award letters (for unearned income) may be used to determine income. NOTE: An SSI recipient is categorically eligible for AHCCCS.

4. AHCCCS/KidsCare Eligibility. All persons being served through Primary Care Program funds shall be screened for AHCCCS/KidsCare eligibility. This screening

shall occur through a two-step process.

a. Verification of enrollment shall be obtained from the AHCCCS/KidsCare Verification Unit, which is staffed 24 hours a day, seven days a week. Call the AHCCCS/KidsCare Verification Unit at:

Phoenix: (602) 417-4000
All Others: 1-800-962-6690

Providers should be prepared to give the operator the following information:

- Provider ID number
- Client's name, date of birth, and AHCCCS/KidsCare identification number or Social Security number

Providers may verify AHCCCS/KidsCare eligibility through the on-line Eligibility Verification System (EVS), by providing the client's social security number, name, date of birth, and gender. Use of the EVS confirms current or past enrollment only and does not preclude potential AHCCCS/KidsCare eligibility. For additional information on EVS, contact the Information Services Division at (602) 417-4000.

b. If not currently enrolled in AHCCCS/KidsCare, then the individual shall be screened for potential AHCCCS/KidsCare eligibility. This screening shall be accomplished through one of the following two methods:

i. Submission of an AHCCCS/KidsCare application. For persons with an annual gross family income of 200% of the Federal Poverty Level or less, and who otherwise meet AHCCCS/KidsCare eligibility standards (i.e., U.S. citizenship or qualified alien status), an AHCCCS/KidsCare application shall be submitted. A denial letter shall constitute verification of AHCCCS/KidsCare ineligibility and shall be kept in the client's file.

ii. Completion of an AHCCCS/KidsCare ineligibility verification form (see attached, this Appendix). For persons with an annual gross family income level of 200% of the Federal Poverty Level or less, and who **do not** otherwise meet AHCCCS/KidsCare eligibility standards (i.e., U.S. citizenship or qualified alien status), an AHCCCS/KidsCare ineligibility verification form shall be completed and signed by the client and clinic representative. This completed form shall be kept in the client's file as verification of AHCCCS/KidsCare ineligibility.

5. Medicare Eligibility. Persons age 65 and over or receiving Social Security Disability benefits for two or more years may be eligible for Medicare.

The Social Security Administration issues a Medicare card giving the beneficiary name, Health Insurance Claim Number (HICN) and the effective date for Medical Insurance ("Part B") coverage. The Contractor may require the Client to obtain a letter from the Social Security Administration verifying the client is not eligible for Medicare. Due to federal confidentiality laws, the Social Security Administration will not release that information to the Contractor. The client may either go to the nearest Social Security office or call 1-800-772-1213 (Social Security Hotline) to obtain a letter of verification.

AHCCCS Ineligibility Verification Form

I have had the eligibility requirements for the Arizona Health Care Cost Containment System (AHCCCS) explained to me, and any questions I had have been answered. I hereby certify that I understand the requirements, and that I am not eligible for AHCCCS benefits.

I understand that if my eligibility status changes, I must inform the clinic.

_____

Client name (type or print)

_____ _____

Client signature Date

_____

Clinic Representative name (type or print)

_____ _____

Clinic Representative signature Date

Verificación de inelegibilidad de AHCCCS

Me han explicado los requerimientos de elegibilidad del sistema de contenimiento del costo de salud de Arizona conocido como (AHCCCS) y todas mis preguntas han sido contestadas. Certifico que entiendo los requerimientos y que no soy elegible para los beneficios de AHCCCS.

Finalmente, entiendo que si mi status de elegibilidad cambia tengo que notificar a la clínica.

_____
Nombre del Cliente (escriba o deletreé)

_____
Firma del ClienteFecha

_____
Nombre del trabajador de elegibilidad (escriba o deletreé)

_____
Firma del trabajador de elegibilidadFecha

APPENDIX E

Primary Care Program - Funded Health Services Intake/Eligibility Form

A. Demographic Information

Client/Patient's Full Name | Birthdate | SPID | Gender | Race/Ethnicity

Street Address | Apt/Unit# | City, State | Zip Code | Area Code/Phone#

Marital Status: ___ Single ___ Married ___ Other

B. Examine proof of Arizona residency (use one of the following and make a copy for client's eligibility file):

- ☐ Recent utility bill showing an Arizona address
- ☐ Letter from a non-relative landlord/neighbor stating that patient lives at Arizona address
- ☐ Mortgage, lease or rent receipt
- ☐ Paystub with client's name and address imprinted on it
- ☐ Arizona motor vehicle registration (not a driver's license)

C. Confirm medical insurance status (check method used):

- ☐ Client not currently enrolled in AHCCCS per Verification Unit or Medifax
  Date & Time of call:_____AHCCCS Clerk Name:
- ☐ Client has a letter of denial from AHCCCS (make a copy for eligibility file)
- ☐ Client is ineligible for Medicaid/Medicare

D. Determine client/household annual income. Indicate documents viewed as verification of income (make copy for eligibility file):

- ☐ Paychecks or paystubs
- ☐ Unearned income (veterans/military benefits, Social Security benefits, SSI, SSA, child support, etc.)
- ☐ Tax forms for most recent year (IRS forms, W-2s)
- ☐ Letter of income verification from employer
- ☐ Client self-declaration

Start date of documentation: _____ End date:
Gross income for period: _____ Gross annual income:

E. Household Size: Include all members physically residing in the household and for whom the Client/Head of Household is financially responsible for supporting (include Head of Household in the first block).

Name	Birthdate	Birthplace (State/Country)	Relationship to Client	Marital Status

Is client currently pregnant? ___ Yes ___ No (If Yes, and patient is a U.S. citizen/legal resident, refer to Baby Arizona/S.O.B.R.A. If Yes and NOT a legal resident, refer to nearest D.E.S. office to apply for F.E.S.)

Is client likely to qualify for AHCCCS due to very low income or chronic illness (spend down)? ___ Yes ____ No (If Yes and patient is a legal resident, client may be eligible for AHCCCS; refer to D.E.S.)

F. Determination of Federal Poverty Level & Sliding Fee Scale Payment:

- ☐ Household Size (from table F) _____
- ☐ Federal Poverty Level (from current federal guidelines) _____%
- ☐ Client's Sliding Fee Scale (SFS) category (what percentage of total charges will the client be responsible for) _____%
- ☐ If SFS category is 0%, will client pay an administrative/office fee? __Yes __No
  If Yes, indicate amount of fee. _____

G. Eligibility Determination

- ☐ Based on FPL and medical insurance status information indicated above, client is eligible for Primary Care Program-funded health services. ___ Yes ____ No
- ☐ Date of eligibility determination: _____

H. Eligibility Re-determination

Primary Care Program clients maintain their eligibility to receive services for one year from the date of eligibility determination. Pending any changes in income or insurance status, re-determination of client eligibility must be conducted prior to:

_____
(month/year)

I affirm that the information I have provided to qualify for Primary Care Program-funded health services is accurate and true to the best of my knowledge. I understand that if I have willfully falsified this application, I may be disqualified from the program. I understand that this program covers primary care services only and only those services ordered by a Primary Care Program-funded provider. I also understand my sliding fee scale payment responsibilities. I understand that if I have any grievances about the program or the sliding fee scale, I may contact the office listed below.

_____ _____
Client Signature(Parent or Guardian, if minor) Date

_____ _____
Clinic/Facility Representative Date

_____
Clinic/Facility Name Site ID Number

_____ _____
Clinic/Facility Address Clinic/Facility 24hr. Phone Number

APPENDIX F

(Optional)

Primary Care Program Health Services Decision Notice

You have been determined to be eligible for Primary Care Program Health Services, funded by the Arizona Department of Health Services (ADHS). Under this program, you can receive primary care services to include immunizations, health education, pharmacy, preventive care and medical treatments performed in a primary care setting, and preventive and basic dental treatments. The ADHS Primary Care Program **does not** cover specialty care or hospital services.

You may be required to pay a nominal office fee or, if your Federal Poverty Level (FPL) is determined to be greater than 100%, you may be required to contribute a payment toward the cost of health services provided under this program. The amount of this payment or co-pay will be based on a Sliding Fee Scale. Payment is due at the time services are rendered. You must notify the eligibility counselor at your service site if there is any change in your household size, income, or residency.

Eligible Client Information:

Client's Full Name	**D.O.B.**	**SPID**	**Race/Ethnicity**	**Gender (M or F)**

Street Address	**Apt/Unit#**	**City, State**	**Zip Code**	**Area Code & Phone Number**

Percent Copay: _____ This is the percent of charges that you are required to pay for services.

Expiration Date: _____ This is the date upon which your eligibility for the program will end. You must contact the eligibility counselor to have your eligibility re-determined.

******The ADHS Primary Care Program **does not** cover specialty care, emergency services or hospital services. In the event that your primary care provider refers you for specialty services to include consultation and/or diagnostic procedures, you may be responsible for all or a portion of any charges resulting from such a referral.******

I understand the benefits and service limitations under this program and my payment responsibilities. I understand that if I have any grievances about this program, I may speak with the health facility listed below. I understand that unless I have my eligibility status re-determined, my eligibility for Primary Care Program services will expire on the date indicated above. By accepting services under the ADHS Primary Care Program, I hereby allow the release of any and all information required for billing to the Arizona Department of Health Services.

Patient Signature (Parent/Guardian Signature, if minor)	**Date**

Facility Representative	**Name of Health Care Facility**	**Date**

APPENDIX G

PRIMARY CARE PROGRAMS (PCP)

QUARTERLY PROGRESS REPORT

NOTE: Quarterly Reports must be received by the ADHS Office of Health Systems Development within 30 days following the end of the quarter. Failure to submit Quarterly Reports in a timely manner may result in suspension of PCP program payments. Send reports to:

Arizona Department of Health Services
Office of Health Systems Development
1740 West Adams, Room 410
Phoenix, Arizona 85007

Phone: 602-542-1219
FAX: 602-542-2011

Contractor Organizational Name:_____

Current Contract Term: (i.e. July 1, 2005 – June 30, 2006) _____

Quarter covered in this report (circle one):

a. July 1 – September 30
b. October 1 – December 31
c. January 1 – March 31
d. April 1 – June 30

Contract Number:_____

Contact Person Name: _____ Title: _____

Address: _____

Telephone: (___)_____ E-Mail: _____

PLEASE FULLY ADDRESS THE FOLLOWING ON A SEPARATE SHEET (This information will assist your ADHS project officer in assessing the status of your program)

1. Program Objectives: List your PCP objectives and indicate the progress made during the quarter towards meeting these objectives.

2. Achievements: Describe any notable organizational and program achievements during the quarter, such as special recognitions, commendations, accreditation, new grants, new programs and any significant improvements in operations, etc.

3. Patient Success Stories: Indicate (anonymously) any special circumstances where patients particularly benefited from the PCP. Please share patient expressions of appreciation.

4. Key Personnel/Provider Staff Changes: Identify any major changes in key program personnel, organizational staff and/or provider staff.

5. Licensure & Certification: List renewals, cancellations, and changes in status of the licensure, certification or accreditation of all participating PCP facilities.

6. Complaints: Indicate the number and type of complaints from all patients during the quarter (PCP patients need not be specifically identified). Indicate how these were resolved.

7. Services/Sites: List changes in the locations of any of the sites serving PCP patients. List additions, deletions or major changes in the types of services provided, subcontracts for services provided, or providers to which PCP patients are referred for any of the service sites during the quarter.

8. Quality Assurance: Indicate changes, activities and results in your Quality Assurance program over the past quarter, including such activities as training, efforts to improve cultural competency and sensitivity, client satisfaction surveys, and revision of protocols.

9. Education & Outreach: Describe education and outreach activities performed during the quarter to identify and support uninsured, low-income, at-risk individuals and facilitate their access to health services.

10. Other: Indicate any other information that would enhance the understanding of your PCP program.

APPENDIX H

CONTRACTOR'S EXPENDITURE REPORT

Arizona Department of Health Services
Office of Health Systems Development
1740 W. Adams, Room 410
Phoenix, Arizona 85007

1. Contract Number _____

2. Contractor's Name _____

3. Title of Program _____

4. Period Covered From _____ To _____

4A. ☐ Cost Reimbursement - Cumulative Actual Expenditures

☐ Fixed Price

☐ Periodic Report ☐ Final Report

5. CONTRACTOR'S DETAILED STATEMENT OF EXPENDITURES

ACCOUNT CLASSIFICATION	APPROVED BUDGET		ITEMIZED EXPENDITURES		
	Original Budget (a)	Current Revised Budget as of (b)_____	Expenditures (c)	Unpaid Encumbrances (d)	Total Expenditures (e)
COST REIMBURSEMENT: Personal Services and ERE					
Professional and Outside Services					
Travel Expenses					
Other Operating					
Capital Outlay Expense					
Other					
TOTAL					

FIXED PRICE: Type of Unit	Rate Per Unit (1)	Revised Rate as of (2)_____	Number of Units Provided (3)		Total Funds Earned (4)
TOTAL					

ADHS PROGRAM COORDINATOR CERTIFICATION:

☐ Performance satisfactory for payment

☐ Performance unsatisfactory, withhold payment

☐ No Payment Due

PROGRAM COORDINATOR SIGNATURE DATE

CONTRACTOR CERTIFICATION

I certify that this report has been examined by me, and to the best of my knowledge and belief, the reported expenditures are valid, based upon our official accounting records (book of account) and are consistent with terms of the contract. It is also understood that the contract payments are calculated by the Department of Health Services based upon information provided in this report.

AUTHORIZED CONTRACTOR'S SIGNATURE PRINTED TITLE DATE

APPENDIX I

PAYMENT FOR VISITS

PRIMARY CARE PROVIDER VISIT PAYMENT

Payment for one medical visit occurs when a patient has direct contact with a physician, physician assistant or nurse practitioner on a given date. The visit must be for medically necessary covered services and must be recorded in the medical record.

Codes that indicate the direct contact:

PRIMARY CARE VISITS:	99201 – 99205	(new patient)
	99211-99215	(established patient)
	99354, 99355	(prolonged direct contact)
PRENATAL/POSTPARTUM:	59425	(antepartum only)
	59426	(7 or more visits)
	59430	(postpartum only)
PREVENTIVE/EPSDT:	99381-99387	(new patient, by age)
	99391-99397	(established patient, by age)

DENTAL PROVIDER VISIT PAYMENT

Payment for one dental visit occurs when a patient has direct contact with a dentist on a given date. The visit must be for medically necessary covered services and must be recorded in the dental record.

The following dental procedure codes will be indicative of a dental provider visit.*

Diagnostic Services:	
D0120	periodic oral evaluation
D0140	limited oral evaluation-problem focused
D0150	comprehensive oral evaluation
D0160	detailed and extensive oral evaluation-problem-focused, by report
Preventive:	
D1110	prophylaxis – adult
D1120	prophylaxis – child
D1201	topical application of fluoride (including prophylaxis), child

D1203	topical application of fluoride (prophylaxis not included), child
D1204	topical application of fluoride (prophylaxis not included), adult
D1205	topical application of fluoride (including prophylaxis), adult
D1351	sealant, per tooth
D1510	space maintainer-fixed, unilateral
D1515	space maintainer-fixed, bilateral
D1520	space maintainer-removable, unilateral
D1525	space maintainer-removable, bilateral
D1550	recementation of space maintainer
D4341	periodontal scaling and root planing, four or more contiguous teeth or bounded teeth spaces per quadrant
D4355	full mouth debridement to enable comprehensive evaluation and diagnosis
D4910	periodontal maintenance procedures
Restorative:	
D2140	amalgam, one surface, primary or permanent
D2150	amalgam, two surfaces, primary or permanent
D2160	amalgam, three surfaces, primary or permanent
D2161	amalgam, four or more surfaces, primary or permanent
D2330	resin-based composite, one surface, anterior
D2331	resin-based composite, two surfaces, anterior
D2332	resin-based composite, three surfaces, anterior
D2335	resin-based composite, four or more surfaces or involving incisal angle, anterior
D2390	resin-based composite crown, anterior
D2391	resin-based composite, one surface, posterior
D2392	resin-based composite, two surfaces, posterior
D2393	resin-based composite, three surfaces, posterior
D2394	resin-based composite, four or more surfaces, posterior
D2910	recement inlay
D2920	recement crown
D2930	prefabricated stainless steel crown, primary tooth
D2931	prefabricated stainless steel crown, permanent tooth

D2932	prefabricated resin crown
D2940	sedative filling
D2950	core buildup, including any pins
D2970	temporary crown (fractured tooth)
D3110	pulp cap-direct (excluding final restoration)
D3120	pulp cap-indirect (excluding final restoration)
D3220	therapeutic pulpotomy (excluding final restoration)
D3221	gross pulpal debridement - primary and permanent teeth
D3230	pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration
D3240	pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration
Oral Surgery:	
D7210	surgical removal of erupted tooth
D7220	removal of impacted tooth-soft tissue
D7270	tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth
D7285	biopsy of oral tissue - hard (bone, tooth)
D7286	biopsy of oral tissue - soft (all others)
D7510	incision and drainage of abscess-intraoral soft tissue
Adjunctive General Services:	
D9110	palliative (emergency) treatment of dental pain-minor procedure
D9310	consultation (diagnostic service provided by dentist other than practitioner providing treatment)
D9610	therapeutic drug injection, by report

*There may be multiple procedure codes occurring on a given date of service. However, only one dental provider visit will be paid per date of service.

APPENDIX J

Well Woman Healthcheck Program

Program Description

The Well Woman HealthCheck Program (WWHP) is an Arizona Department of Health Services (ADHS) program funded through a cooperative agreement with the United States Centers for Disease Control and Prevention (CDC). In 1990, the United States Congress enacted legislation (P.L. 101-354) which authorized the CDC to establish the National Breast and Cervical Cancer Early Detection Program (NBCCEDP), to provide Pap testing, clinical breast exams, mammography screening and limited diagnostic follow-up services to income and age eligible, uninsured and under insured women throughout the United States. The program is funded via the CDC and the state of Arizona. The WWHP is Arizona's response to NBCCEDP. The WWHP works with its contractors to address five programmatic areas:

1) Coalitions and Partnerships;
2) Public Education and Outreach;
3) Screening, Tracking, Follow-Up and Case Management;
4) Quality Assurance and Improvement; and
5) Professional Education.

Eligibility and Enrollment
This is a screening program. Eligibility must be determined before each screening cycle.

Policy:
Eligibility requirements are:

- Women 65 years of age or older may be enrolled in the Well Woman HealthCheck Program if they are uninsured or under insured and have a gross household income between 100-250% of the federal poverty level or less, and have been residents of Arizona for at least one day with the intention of establishing permanent residence in Arizona. However, if diagnosed with cancer this population of women is not eligible to receive treatment services under the Breast and Cervical Cancer Prevention and Treatment Act of 2000.
- Women 40-64 years of age are eligible for this program, if they are uninsured or under insured and have a gross household income between 100-250% of the federal poverty level, and have been residents of Arizona for at least one-day with the intention of establishing permanent residents in Arizona. Women with an intact cervix or history of cervical neoplasia are eligible to receive Pap test screening in accordance with the WWHP cervical screening policy. Annual clinical breast examination and pelvic examination are included in the office visit reimbursement.

- Symptomatic women below the age of 40 may receive a clinical breast exam to document symptoms of breast cancer, discrete mass, nipple discharge, and skin or nipple changes. If the findings are abnormal and the woman is uninsured or underinsured, have a household income between 100-250% of the federal poverty level, and have been a resident of Arizona for at least one day, she may be enrolled.
- Asymptomatic women under age 40 are not eligible, even if considered to be high risk.
- Men are not eligible for screening or diagnostic services (Public Law 101-354).

Procedure:

1. Determine woman's date of birth. For women under 40 years of age, once their abnormality has been resolved and the recommendation is to return to routine screening intervals, the client should be dis-enrolled from the WWHP and referred to other programs.
2. Determine financial eligibility by using current WWHP Income Eligibility Guidelines, which is based on the Federal Poverty Level (FPL). If the woman is at or below 100% of FPL, she shall be given an AHCCCS application and referral, with assistance if needed to complete the AHCCCS process.
3. Determine residency.
4. Determine insurance status: Uninsured women are those without any insurance coverage. Under insured women are those who have Medicare Part A only, Indian Health Services (IHS), a health insurance policy that does not cover mammograms or pap smears, or any insurance with a deductible that exceeds $100.00. Inability to pay a co-payment of less than $100.00 does not qualify as under insured.
5. Women 65 years or older should be referred to Medicare Parts A and B for health benefits. If a client is unable to pay Medicare premiums she may be eligible for assistance under AHCCCS. If she does not qualify for AHCCCS and has Medicare A only, make a copy, front and back, of her card making sure it clearly reads "Part A; or " hospital coverage only. Attach a copy to the eligibility form. (Note: women 65 years or older are not eligible for AHCCCS under the Breast and Cervical Cancer Treatment Program.)
6. If a woman has insurance, contact the insurance company to confirm her eligibility. If she meets the eligibility criteria, make a copy, front and back, of her card. Attach a copy to the enrollment form.

NOTE:

The Well Woman HealthCheck Program is payor of last resort. Therefore, any woman who has another source of payment is not to be enrolled. The ADHS Primary Care Program is exempt from this notation. Contractors are expected to refer uninsured women to the Well Woman HealthCheck Program who meet the eligibility requirements.

APPENDIX K

DATA REPORTING AND SUBMISSION REQUIREMENTS FOR PRIMARY CARE CONTRACTORS

PURPOSE

The purpose of this policy is to ensure that primary care providers under contract with the Office of Health Systems Development (HSD) of the Arizona Department of Health Services (ADHS) for the delivery of primary care medical and dental services comply with all ADHS contractual requirements for collecting and reporting primary care data. This policy sets forth the specific requirements for submitting primary care data to HSD for program reporting, analysis and evaluation.

POLICY

A. Data Reporting Responsibility

Primary Care Program (PCP) contractors are required to submit to HSD for financial reimbursement all client eligibility and encounter data for medical and dental primary care services that meet PCP eligibility and service requirements. It is important to ADHS to obtain data on all patient visits, even if the PCP contractor has expended their contract award and these visits remain uncompensated by ADHS. The data is used to report service utilization and to demonstrate unmet and unfunded need. Contractor Expenditure Reports (CERs) may also be submitted for inclusion in the contractor's file to further document specific unmet need.

B. Assignment of Contractor and Service Site Identification Numbers

1. Prior to contract award, each PCP contractor will notify HSD of the name and location of all facilities, service delivery sites, and subcontractor sites. The contractor shall also notify HSD within five (5) working days during the contract period of any change in status of a service delivery site.

2. For the purpose of reporting primary care data, HSD will assign a unique contractor identification number to the main contractor facility location and each service delivery or subcontractor site. Each eligibility and service encounter record submitted to HSD shall be identified by the correct code assigned to the service site. A contractor may not change the site code identification numbers assigned by HSD or identify a service delivery site by other than HSD's assigned site code on records submitted for processing.

C. Data Submission Timelines

Eligibility and encounter data shall be submitted to HSD according to the following schedule:

1. Each contractor shall transmit the original data file submission for each month to HSD in an electronic format within twenty (20) calendar days after the end of the service month.

2. If a contractor receives a rejection of an original data file submission or an error report

rejecting specific data records, the contractor shall correct the data records and resubmit the file within ten (10) calendar days following receipt of the HSD rejection notice. The contractor's resubmission shall contain only those records that have been corrected. HSD will accept no more than three (3) resubmissions of a contractor's data file for any given month.

D. General Requirements for Data Files/Records

The PCP contractor shall submit data to HSD for PCP clients only as follows:

1. Client eligibility records shall be submitted in accordance with the Intake Eligibility Flat File Format, Attachment 1.

2. Client medical and dental encounter records shall be submitted in accordance with the HCFA 1500 Database Flat File Format, Attachment 2.

3. Each eligibility record shall be identified by the correct site code for the facility site where the eligibility determination was made. The site code shall be entered in Field 2 of the Intake Eligibility Flat File form.

4. Each encounter record shall be identified by the correct site code for the facility site where the service was provided. The site code shall be entered in Field 32 of the HCFA 1500 Flat File form.

5. A contractor requesting a change or deletion in a data record shall submit an e-mail to HSD specifying the change or deletion to be made. At the contractor's request, HSD will correct erroneous information and make changes that directly affect the unique client identifier (i.e., the 9-character SPID) on the eligibility or encounter record. These changes may include:

a. Legal client name changes as a result of marriage, divorce or court approval;
b. Erroneous or duplicate names contained in client records;
c. Erroneous date of birth; or
d. Incorrect gender

6. The contractor's request must identify the specific eligibility record or the date of service/ encounter affected by the change. The contractor is not required to submit a new or revised eligibility or encounter record for changes affecting only the SPID identifier.

7. For all other changes not affecting the SPID identifier, the contractor must specify the SPID number and date of service on the record to be changed and state the specific data change(s) or deletion(s) to be made. The contractor is required to submit a new or revised eligibility or encounter record for all changes not affecting the SPID. Please note: HSD can make record changes in a data file for the current month only, and does not have the capability to change the client's historical record.

E. Data Submission Requirements

1. Submission of Data Files

a. Primary care eligibility and HCFA 1500 encounter files shall be transmitted to HSD in an electronic format. E-mail via the Internet is the preferred and recommended method of data submission. Data files transmitted by e-mail shall be addressed to HSD @azdhs.gov. The specific e-mail address of the person designated by HSD to receive the data will be made known to the contractor as required to meet this objective.

b. If a contractor does not have the capability to submit the monthly data files to HSD by e-mail, the contractor may send the data on a 3-1/2 inch electronic disk by certified or priority U.S. mail, or it may be hand-delivered by courier, provided that the data is received by HSD in accordance with the required data submission schedule/due dates. The disk shall be addressed or delivered to: ADHS Office of Health Systems Development, 1740 W. Adams, Room 410, Phoenix, AZ 85004.

2. Data Confidentiality

HSD and all primary care contractors shall ensure that the security and confidentiality of all primary care client data is protected during transmission to and from HSD by zipping and password protecting the files. The contractors shall comply with the security and confidentiality requirements of the Health Insurance Portability and Accountability Act (HIPAA).

3. ASCII Format

a. Client eligibility information/data will be submitted in the Intake/Eligibility Form Flat File Format in ASCII fixed length text. In accordance with existing policy, HSD will reject client eligibility records that have incomplete information in the 8 mandatory fields (see F.3.a, p. 5) or that contain additional information not specified in the Intake/Eligibility Flat File format.

b. Client encounter information/data will be submitted in the HCFA 1500 Database Flat File Format in ASCII fixed length text. In accordance with existing policy, HSD will reject client encounter records that have incomplete information in the 7 mandatory fields (see F.3.b, p.6) or that contain additional information or extra fields not specified in the HCFA 1500 Flat File format.

c. Each contractor shall format and code the primary care intake eligibility and encounter data for submission to HSD using the ASCII fixed length text file format and coding.

4. Naming Convention for Data Files

a. Contractor data files transmitted to HSD shall be named in accordance with the following standard naming convention utilizing seven (7) standard characters:

1st character	e (eligibility) or h (HCFA encounters)
2nd and 3rd characters	first 2 digits of the contractor site number
4th and 5th characters	last 2 digits of the fiscal year (04, 05, etc.)
6th and 7th characters	number of the month (05, 06, etc.)

Example: e210106.txt

b. Data files for a service month are limited to 3 resubmissions. Resubmitted data file names will identify a file resubmission by adding [r1], [r2], or [r3] as the 8th or 9th identifier.

Example: e210106r1.txt

5. Electronic Transmission Labeling for E-mail

The required data submitted to HSD by e-mail shall be labeled with the following summary information:

a. Contractor/facility name
b. Contact person
c. Telephone number
d. Contractor number assigned by HSD
e. Site identification number
f.. Type of data transmitted (eligibility and/or encounter)
g. Reporting period (month/year for which data is reported)
h. Date of submission
i. Type of submission (original submission or resubmission)
j. Record count (number of eligibility records and/or encounter records)

6. Electronic Transmission Labeling for Disk:

If a contractor is unable to submit data files to HSD via e-mail, the required data may be submitted on an electronic disk. The disk shall be labeled in accordance with the same information as listed in #5 above.

7. Sequence of Data Submissions by Month

In order to correctly maintain the HSD database, HSD will not process any monthly data files out of sequence or for any month for which the data files of all prior months have not been received from a contractor. All contractors are required to submit their monthly data files to HSD in regular, sequential order. Contractor data files received by HSD for any given month will not be processed until HSD has received correct and complete data files from that contractor for all prior months.

8. Definition of an Error-Free Data Record

An error-free data record is one that conforms to the ASCII fixed length text file format, is coded correctly, and has no incorrect or missing data. No additional information is required from a contractor if the data file is error-free.

F. Data Processing Specifications

HSD has established the following standard policy and procedures for processing contractor primary care data files:

1. Pre-check to Determine Acceptability/Rejection of a Contractor's Data File

Upon receipt, HSD will conduct a preliminary check of the file to determine its acceptability for processing. A data file shall be deemed unacceptable for analysis if it cannot be processed by

HSD because of inherent problems with the data that include, but are not limited to, the following:

a. Data submission is on a faulty disk,
b. Data file is not labeled as required, or
c. Data is not in the required ASCII fixed length text file format or incorporates mixed formats.

HSD will automatically reject an entire data file as unacceptable for any of the above reasons and return the file immediately to the contractor for correction. If the contractor corrects the file and returns it to HSD by the due date for that month, the file will be acceptable.

2. Priority Sequence of Data File Processing

HSD will process the data files received from contractors according to the following priority sequence:

a. Data file submissions received by the 20th of the month and included in the regular batched data processing run.
b. Resubmissions of data files that contain required file corrections and are received by HSD within the standard 10-day resubmission period.
c. Any original data files submitted after the 20th of the month will be processed separately and individually after HSD has completed the processing of the regular batch run and all file resubmissions. The late files will be processed in order according to the date received and as HSD staff and resources become available for processing.

3. Mandatory Fields - Client Records

a. Client Eligibility Intake Record

HSD will reject a client eligibility intake record if the data is incomplete, incorrect or missing in the following eight (8) mandatory fields:

(1) Patient's ID Number
(2) Site ID Number (location of eligibility determination)
(3) Patient's Date of Birth
(4) Household Residence State
(5) Household Gross Income
(6) Household % of Poverty
(7) Date of Eligibility Status
(8) Eligibility Status Code

b. Client Encounter Record

HSD will reject a client encounter record if the data is incomplete, incorrect or missing in the following seven (7) mandatory fields:

(1) Patient's ID Number
(2) Patient's Date of Birth
(3) Patient's Residence State
(4) Diagnosis Code 1 (dia_1) (first ICD-9 Code)
(5) Date of Encounter
(6) CPT1 as the first procedure (first CPT or HCPCS code)

(7) Facility Site ID Number (location of service delivery)

4. Error Rate

a. Upon receipt of an original data file submission, HSD will process the eligibility and encounter records to pre-check the mandatory fields in each record, validate data format and accuracy, and calculate a data file error rate based on the percent of records that fail and are rejected due to one or more errors in the mandatory fields.

b. The acceptable error rate established by this policy is 4.0 percent (4%) calculated only on the mandatory fields of the eligibility and encounter records as identified in F.3.a and F.3.b, above. Multiple errors in the eligibility and encounter records of a single patient will be counted only as one error when calculating the error rate for the entire data file. HSD will notify the contractors of the error rates on a monthly basis. Only claims without errors can be processed for payment.

Example:

A contractor submits a data file containing 100 patient records, of which 4 records fail the pre-check due to one or more errors in the mandatory fields of either the patient eligibility record or the encounter record, or both. The errors in either of these records will cause the encounter records of the 4 patients to fail. The 4 failed encounter records constitute a data file error rate of 4 percent, calculated as 4/100 = .04 (4%). The error rate is based on the number of records that fail because of one or more errors in a mandatory field, not on the number of errors in the records.

c. HSD will reject a patient record and generate an error report if:

(1) The patient eligibility intake record contains incomplete, incorrect or missing data in any of the 8 mandatory fields.
(2) The patient encounter record contains incomplete, incorrect or missing data in any of the 7 mandatory fields.

5. Contract Noncompliance

A contractor's failure to meet the data submission requirements set forth in this policy constitutes contract noncompliance. Unless a contractor receives prior approval by HSD to be late with the data submission requirement, payment to the contractor may be delayed until the data is received. Additional contractual remedies may be considered for on-going noncompliance.

INTAKE / ELIGIBILITY FORM PRIMARY CARE PROGRAM FLAT FILE FORMAT

FIELD #	FIELD	DESCRIPTION	START	LENGTH	TYPE	FORMAT	JUSTIFICATION
01	pat_id	Patient's ID Number	001	**15**	A	**No punctuation or spaces**. All digits must be filled in. Use leading zeros to fill (SPID: **000000AA010190M** first name initial - last name initial - date of birth - gender: Totaling 9 characters plus lead zeros).	**Right** justified with leading zeros
02	site_id	Site ID Number (Place of Service)	016	**05**	A	Two-digit contract code plus three-digit subcontractor code as assigned by HSE (i.e. **05003**).	**Right** justified with leading zeros
03	pat_dob	Patient's Date of Birth	021	**08**	A	**MMDDYYYY** format (i.e. September 5, 1997 = **09051997**)	**Left** justified
04	pat_mar	Patient's Marital Status	029	**01**	A	**1** = Single **2** = Married **3** = Other	
05	race_eth	Patient's Race/Ethnicity	030	**01**	A	**A** = Asian **B** = Black **H** = Hispanic **I** = Native American **P** = Pacific Islander **W** = White **O** = Other	
06	pat_add	Household Residence Address	031	**29**	A	Street number (space)Street name(space)Apartment number	**Left** justified
07	pat_cit	Household Residence City	060	**15**	A	Arizona city	**Left** justified
08	pat_st	Household Residence State	075	**02**	A	Two-letter state abbreviation (**AZ**)	**Left** justified
09	pat_zip	Household Residence ZIP Code	077	**05**	A	Five digit ZIP code	**Left** justified
10	gros_inc	Household Gross Income	082	**07**	A	Enter gross annual income from 0 to nearest whole dollar. No punctuation. All digits must be filled in.	**Right** justified with leading zeros
11	fpl_perc	Household % of Poverty	089	**03**	A	Where client falls on the Federal Poverty Level (FPL). Range: Less than or equal 200% of FPL, range **000-200%** (i.e. **099**)	**Right** justified with leading zeros
12	sfs_hous	Household Sliding Fee Scale	092	**03**	A	Percent of charges the client is responsible to pay, range **000 - 100%** (i.e. **050**).	**Right** justified with leading zeros
13	eff_date	Date of Eligibility Status	095	**08**	A	**MMDDYYYY** Format (i.e. September 5,1997 = **09051997**)	**Left** justified
14	stat_chg	Status	103	**01**	A	**A =** Eligible **B =** Eligible and applying for AHCCCS **C =** No longer Eligible **D =** Re-establishing Eligibility	
15	hlth_ins	**(FOR ADHS USE ONLY)**	104	**02**	A	00 = Self Pay (None) 01 = Commercial (indemnity) 02 = HMO 03 = PPO 04 = AHCCCS Health Care Group 05 = Medicare 06 = AHCCCS/Medicaid 07 = CHAMPUS/MEDEXCEL 08 = Children's Rehabilitation Svcs 09 = Workers Compensation 10 = Indian Health Services 11 = Medicare Risk 12 = Charity 13 = Foreign National 14 = Other	**Right** justified with leading zero for the 00 through 09
16	prev_ser	**(FOR ADHS USE ONLY)**	106	**01**	A	Y = Yes N = No	

HCFA 1500 Database - Flat File Format

FIELD	FLD_NAM	DESCRIPTION	START	LENGTH	TYPE	FORMAT	JUSTIFICATION
1	Pat_id	Patient's ID Number	001	**15**	**A**	**No punctuation or spaces.** All digits must be filled in. Use lead zeros to fill (SPID: **000000AA010190M** first name initial - last name initial of birth - gender: totaling 9 characters plus lead zeros).	Right justified with lead zeros
2	Pat_dob	Patient's Date of Birth	016	**8**	**A**	**MMDDYYYY** format (i.e. September 5, 1997 = **09051997**)	Left justified
3	Pat-sex	Patient's Sex	024	**1**	**A**	**M** - Male **F** - Female	
4	Pat_add	Patient's Address	025	**29**	**A**	Street number(space)Street name(space)Apartment number	Left justified
5	Pat_cit	Patient's City	054	**15**	**A**	Arizona city	Left justified
6	Pat_st	Patient's State	069	**2**	**A**	**Two**-letter state abbreviation (**AZ**)	
7	Pat_zip	Patient's ZIP Code	071	**5**	**A**	**Five** digit ZIP Code	
8	Pat_rel	Patient's Relationship to Insured	076	**1**	**A**	**ADULT** **1** – Self - Always **CHILD** **1** – Self - Always	
9	Pat_mar	Patient's Marital Status	077	**1**	**A**	**ADULT** **1** – Single **3** – Other **2** - Married **CHILD** **1** – Single - Always	
10	Pat_emp	Patient's Employment Status	078	**1**	**A**	**ADULT** **1** – Employed **3** - Not in the Labor Force **2** - Unemployed **CHILD** **3** - Not in the Labor Force	
11	Pat_stu	Patient's Student Status	079	**1**	**A**	**ADULT** **1** - Full-time Student **3** - Non-student **2** - Part-time Student **CHILD** ***** To be filled out respectively	
12	Ins_plan	Insurance Plan Name	080	**25**	**A**	No punctuation. (Insurance Plan Name only) **PCP**	Left justified
13	Ref_phy	Name of Referring Physician	105	**26**	**A**	Last Name (space) First Name **(Only if you refer clients outside of your organization)**	Left justified

14	Id_reph	ID# of Referring Physician	131	**6**	**A**	No punctuation or spaces. All digits must be filled in. **(Only if you refer clients outside of your organization)**	Right justified with lead zeros
15	Dia_1	Diagnosis Code 1	137	**6**	**A**	**XXX.YY** format. Include decimal and applicable letter. If code consists of less than six (6) places, including the decimal, do not fill the blank(s) on the right. **(Codes must be specific)**	Left justified
16	Dia_2	Diagnosis Code 2	143	**6**	**A**	**XXX.YY** format. Same as instructions for the first diagnosis code.	Left justified
17	Dia_3	Diagnosis Code 3	149	**6**	**A**	**XXX.YY** format. Same as instructions for the first diagnosis code.	Left justified
18	Dia_4	Diagnosis Code 4	155	**6**	**A**	**XXX.YY** format. Same as instructions for the first diagnosis code.	Left justified
19	DOV	Date of Encounter	161	**8**	**A**	**MMDDYYYY** format (i.e. September 5, 1997 = **09051997**)	
20	Cpt1_hcpc	1 - Procedure CPT/HCPCS	169	**5**	**A**	Service Code	Left justified
21	Pr1_mod1	1 - Procedure Modifier 1	174	**2**	**A**	**2** digit Modifier Code (Can have 0, 1 or 2 characters)	Left justified
22	Pr1_mod2	1 - Procedure Modifier 2	176	**2**	**A**	**2** digit Modifier Code (Can have 0, 1 or 2 characters)	Left justified
23	Dc_1	1 - Diagnosis Code	178	**4**	**A**	**1** - Diagnosis Code 1 **(Which diagnosis code does this CPT code refer to?)** **2** - Diagnosis Code 2 **3** - Diagnosis Code 3 **4** - Diagnosis Code 4	Left justified. No commas if more than one digit of Diagnosis Code is appropriate.
24	Chrg_1	1 - Charges	182	**6**	**A**	Enter amount to nearest whole dollar. No punctuation. All digits must be filled in.	Right justify with leading zeros
25	Cpt2_hcpc	2 - Procedure CPT/HCPCS	188	**5**	**A**	Service Code	Left justify
26	Pr2_mod1	2 - Procedure Modifier 1	193	**2**	**A**	**2** digit Modifier Code (Can have 0, 1 or 2 characters)	Left justify
27	Pr2_mod2	2 - Procedure Modifier 2	195	**2**	**A**	**2** digit Modifier Code (Can have 0, 1 or 2 characters)	Left justify
28	Dc_2	2 - Diagnosis Code	197	**4**	**A**	**1** - Diagnosis Code 1 **(Which diagnosis code does this CPT code refer to?)** **2** - Diagnosis Code 2 **3** - Diagnosis Code 3 **4** - Diagnosis Code 4	Left justified. No commas if more than one digit of Diagnosis Code is appropriate.
29	Chrg_2	2 - Charges	201	**6**	**A**	Enter amount to nearest whole dollar. No punctuation. All digits must be filled in.	Right justify with leading zeros

30	Cpt3_hcpc	3 - Procedure CPT/HCPCS	207	**5**	**A**	Service Code	Left justify
31	Pr3_mod1	3 - Procedure Modifier 1	212	**2**	**A**	**2** digit Modifier Code (Can have 0, 1 or 2 characters)	Left justify
32	Pr3_mod2	3 - Procedure Modifier 2	214	**2**	**A**	**2** digit Modifier Code (Can have 0, 1 or 2 characters)	Left justify
33	Dc_3	3 - Diagnosis Code	216	**4**	**A**	**1** - Diagnosis Code 1 **(Which diagnosis code does this CPT code refer to?)** **2** - Diagnosis Code 2 **3** - Diagnosis Code 3 **4** - Diagnosis Code 4	Left justified. No commas if more than one digit of Diagnosis Code is appropriate.
34	Chrg_3	3 - Charges	220	**6**	**A**	Enter amount to nearest whole dollar. No punctuation. All digits must be filled in.	Right justify with leading zeros
35	Cpt4_hcpc	4 - Procedure CPT/HCPCS	226	**5**	**A**	Service Code	Left justify
36	Pr4_mod1	4 - Procedure Modifier 1	231	**2**	**A**	**2** digit Modifier Code (May have 0, 1 or 2 characters)	Left justify
37	Pr4_mod2	4 - Procedure Modifier 2	233	**2**	**A**	**2** digit Modifier Code (May have 0, 1 or 2 characters)	Left justify
38	Dc_4	4 - Diagnosis Code	235	**4**	**A**	**1** - Diagnosis Code 1 **(Which diagnosis code does this CPT code refer to?)** **2** - Diagnosis Code 2 **3** - Diagnosis Code 3 **4** - Diagnosis Code 4	Left justified. No commas if more than one digit of Diagnosis Code is appropriate.
39	Chrg_4	4 - Charges	239	**6**	**A**	Enter amount to nearest whole dollar. No punctuation. All digits must be filled in.	Right justify with leading zeros
40	Cpt5_hcpc	5 - Procedure CPT/HCPCS	245	**5**	**A**	Service Code	Left justify
41	Pr5_mod1	5 - Procedure Modifier 1	250	**2**	**A**	**2** digit Modifier Code (Can have 0, 1 or 2 characters)	Left justify
42	Pr5_mod2	5 - Procedure Modifier 2	252	**2**	**A**	**2** digit Modifier Code (Can have 0, 1 or 2 characters)	Left justify
43	Dc_5	5 - Diagnosis Code	254	**4**	**A**	**1** - Diagnosis Code 1 **(Which diagnosis code does this CPT code refer to?)** **2** - Diagnosis Code 2 **3** - Diagnosis Code 3 **4** - Diagnosis Code 4	Left justified. No commas if more than one digit of Diagnosis Code is appropriate.
44	Chrg_5	5 - Charges	258	**6**	**A**	Enter amount to nearest whole dollar. No punctuation. All digits must be filled in.	Right justify with leading zeros
45	Cpt6_hcpc	6 - Procedure CPT/HCPCS	264	**5**	**A**	Service Code	Left justify

46	Pr6_mod1	6 - Procedure Modifier 1	269	**2**	**A**	**2** digit Modifier Code (Can have 0, 1 or 2 characters)	Left justify
47	Pr6_mod2	6 - Procedure Modifier 2	271	**2**	**A**	**2** digit Modifier Code (Can have 0, 1 or 2 characters)	Left justify
48	Dc_6	6 - Diagnosis Code	273	**4**	**A**	**1** - Diagnosis Code 1 **(Which diagnosis code does this CPT code refer to?)** **2** - Diagnosis Code 2 **3** - Diagnosis Code 3 **4** - Diagnosis Code 4	Left justified. No commas if more than one digit of Diagnosis Code is appropriate.
49	Chrg_6	6 - Charges	277	**6**	A	Enter amount to nearest whole dollar. No punctuation. All digits must be filled in.	Right justify with leading zeros
50	Tot_chg	Total Charges	283	**7**	A	Enter amount to nearest whole dollar. No punctuation. All digits must be filled in.	Right justify with leading zeros
51	Amt_pd	Amount Paid	290	**7**	A	Enter amount to nearest whole dollar. No punctuation. All digits must be filled in.	Right justify with leading zeros
52	Bal_due	Balance Due	297	**7**	A	Enter amount to nearest whole dollar. No punctuation. All digits must be filled in.	Right justify with leading zeros
53	Fac_site	Facility Site	304	**5**	A	Two-digit contract code plus three-digit subcontractor code as assigned by HSE (i.e. 05003).	Left justify
54	Phy_id	Physician's ID (State License/Certification #)	309	**12**	A	No punctuation or spaces. All digits must be filled in.	Right justified with lead zeros
55	Phy_fnam	Physician's First Name and MI	321	**12**	A	First Name (space) Middle Initial (if known)	Left justify
56	Phy_lnam	Physician's Last Name	333	**20**	A	Lname	Left justify

GUIDANCE FOR COMPLETING THE FLAT FILE FORMATS

The encounter and eligibility files should be submitted in an ASCII fixed length text as illustrated in the Program Guidance Manual, Appendix L. Please note the starting positions and ending positions of each field.

The SAS program that interprets and validates the flat file format is case sensitive. Therefore, please use either all capital or all lower-case letters. If the SPIDS are not keyed identically, the program will not be able to match the records for validation. Mismatched records increase error rates and cause billable claims to be rejected.

A. ELIGIBILITY FILE FORMAT

Use this guidance to enter the eligibility fields as follows:

1. Field #1: Patient's ID Number (Required Field)
Positions: 1-15
Characters: 15, alpha-numeric
Justification: right

This field contains six leading zeros followed by the first initial of the patient's first name, first initial of the patient's last name, a six digit date format for the patient's date of birth, and a single letter indicating the sex of the patient.

Example: leading zeros = 000000
Louise Apostle = LA
May 23rd, 1947 = 052347 (no slashes)
Female = F
SPID = 000000LA052347F

a. If you have two patients who are same sex twins with the same initials, differentiate them by assigning a one (1) to one of them. Place the one in front of the first initial. Example:
First Twin = 000000LA052347F
Second Twin = 000001LA052347F

b. If you have three patients who are same sex triplets with the same initials, assign a one (1) and a two (2) to the second and third patients, respectively.

2. Field #2: Site ID Number (Required Field)
Positions: 16-20
Characters: 5, numeric
Justification: right

This number is assigned by Office of Evaluation and Statistics and is as follows: The first two digits are assigned to the contractor. From left to right, the third (3rd) and fourth (4th) positions are reserved for indicating the individual clinic operating under the contractor.

Example: 99000 – This number is assigned to the main contractor.

99001 – This number is assigned to a clinic and is issued in descending order for each additional clinic.

Each clinic is given its own site id number, which corresponds to the address of the clinic. If a clinic's location changes, a new number is assigned to it. The numbers are fixed geographically and cannot ever be used again unless the contractor re-opens the same clinic at the same address. If a contractor is not granted a contract for any given year, previously assigned site numbers will always belong to that organization in case they ever obtain another contract to provide health care services with ADHS funds.

3. Field #3: Patient's Date of Birth (Required Field)

Positions: 21-28
Characters: 8, numeric
Justification: left

This number is the patient's date of birth without any slash marks (05231947).
Date Format: MMDDYYYY

4. Field #4: Patient's Marital Status (Warning if missing)

Position: 29
Character: 1, numeric
1 = Single
2 = Married
3 = Other (covers divorced and widowed categories)

5. Field #5: Patient's Race/Ethnicity (Warning if missing)

Position: 30
Character: 1, alpha

This position is used to indicate the patient's race or ethnicity. The characters are assigned as follows:

A = Asian
B = Black
H = Hispanic
I = Native American
P = Pacific Islander
W = White
O = Other

6. Field #6: Household Residence Address (Warning if missing)

Positions: 31-59
Characters: 29, alpha-numeric
Justification: left

This field cannot be left blank, keyed as "unknown", or "moved", or contain characters obviously not part of the patient's address. This field should be keyed as follows:

Street number (a single space)
Street name (a single space) - abbreviations for names are allowed
Apartment \Lot\space number

For a client who is homeless, please provide a directional address.
Examples: Under bridge at I-10/I-17
Bus stop at 23dr/camelback

7. Field #7: Household Residence City (Warning if missing)

Positions: 60-74
Characters: 15, numeric
Justification: left

Abbreviations may be used in this field but it must be an Arizona city.

8. Field #8: Household Residence State (Required Field)

Positions: 75-76
Characters: 2, alpha
Justification: left

This field should always be "AZ".

9. Field #9: Household Residence Zip Code (Warning if missing)

Positions: 77-81
Characters: 5, numeric
Justification: left

10. Field #10: Household Gross Income (Required Field)

Positions: 82-88
Characters: 7, numeric
Justification: right

Please do not use dollar signs, decimals, or cents, because they will cause the encounter to fail. This number should be rounded to the nearest dollar. Example: The client has an annual income of $8,364.65 – This should keyed as: 0008365 The leading zeros complete the seven (7) digit number field.

11. Field #11: Household % of Poverty (Required Field)

Positions: 89-91
Characters: 3, numeric
Justification: right

This number indicates where the client falls on the Federal Poverty Level. The maximum allowable number for this program is two hundred percent (200 %). This number needs to be exact and leading zeros are needed for those below 100 % to complete the field. Do not key the percentage sign in this field. Example: Range = 000 through 200

12. Field #12: Household Sliding Fee Scale (Warning if missing)

Positions: 92-94
Characters: 3, numeric
Justification: right

This field shows the percentage of charges the client is responsible paying and should be keyed in as follows: Range = 000 through 100

13. Field #13: Date of Eligibility Status (Required Field)

Positions: 95-102
Characters: 8, numeric
Justification: left

This number is the date the patient was determined to be eligible for the Primary Care Program. The date of birth is keyed without any slash marks (07012002). Date Format: MMDDYYYY

14. Field #14: Status (Required Field)

Position: 1
Character: 1, alpha

This field indicates the patient's eligibility status. The characters are assigned as follows:

A = Eligible (good for 396 days, A is used for the first determination) (new patients)
B = Eligible and applying for AHCCCS (45 day limit)
C = No longer eligible
D = Re-establishing eligibility

15. Fields # 15 and 16

These fields are reserved for ADHS future use. Do not key anything past the Status code at position number one hundred three (103). This will cause the claim to fail the pre-check and be returned to you for correction, causing the billable claim to fail.

B. ENCOUNTER FILE FORMAT

Use this guidance to enter the encounter fields as follows:

1. Field #1: Patient's ID Number (Required Field)

Positions: 1-15
Characters: 15, alpha-numeric
Justification: right

a. This number starts with six leading zeros and is combined with the first initial of the patient's first name, first initial of the patient's last name, a six digit date format for the patient's date of birth, and a single letter indicating the sex of the patient.

Example:	= 000000 (leading 0s)
Louise Apostle	= LA
May 23rd, 1947	= 052347 (no slashes)
Female	= F
SPID	= 000000LA052347F

b. If you have two patients who are same sex twins with the same initials, differentiate them by assigning a one (1) to one of them. Place the one in front of the first initial. Example:

First Twin	= 000000LA052347F
Second Twin	= 000001LA052347F

c. If you have three patients who are same sex triplets with the same initials, assign a one (1) and a two (2) to the second and third patients, respectively.

2. Field #2: Patient's Date of Birth (Required Field)

Positions: 16-23
Characters: 8, numeric
Justification: left

This number is the patient's date of birth without any slash marks (05231947).
Date Format: MMDDYYYY

3. Field #3: Patient's Gender (Warning if missing)

Position: 24
Character: 1, alpha
The category numbers are assigned as follows: M = Male F = Female

4. Field #4: Patient's Address (Warning if missing)

Positions: 25-53
Characters: 29, alpha-numeric
Justification: left

This field cannot be left blank, keyed as "unknown" or "moved", or contain characters obviously not part of the patient's address. This field should be keyed as follows:

Street number (a single space)
Street name (a single space) - abbreviations for names are permitted
Apartment \Lot\space number

Please provide directional addresses for homeless clients. Examples: Under bridge at I-10/I-17; Bus stop at 24th Street/Camelback

5. Field #5: Patient's City (Warning if missing)

Positions: 54-68
Characters: 15, alpha
Justification: left

Abbreviations may be used but this must be an Arizona city.

6. Field #6: Patient's State (Required Field)

Positions: 69-70
Characters: 2, alpha
Justification: left

This field should always be "AZ".

7. Field #7: Patient's Zip Code (Warning if missing)

Positions: 71-75

Characters: 5, numeric
Justification: left

8. Field # 8: Patient's Relationship to Insured (Warning if missing)

Position: 76
Character: 1, numeric

The category number will always be: 1 = Self

9. Field # 9: Patient's Marital Status (Warning if missing)

Position: 77
Character: 1, numeric

This information is based on the patient (adult or child) who is receiving services. The category numbers are defined as:

1 = Single
2 = Married
3 = Other (Covers divorced and widowed categories)

10. Field #10: Patient's Employment Status (Warning if missing**)**

Position: 78
Character: 1, numeric

This information is based on the patient (adult or child) who is receiving services. The category numbers are defined as:

1 = Employed
2 = Unemployed
3 = Not in the Labor Force (always used for children not working)

11. Field #11:Patient's Student Status (Warning if missing)

Position: 79
Character: 1, numeric

This information is based on the patient (adult or child) who is receiving services. The category numbers are assigned as:

1 = Full-time Student (school age children or college students)
2 = Part-time Student (college students)
3 = Non-student (children under age 6 or over age 17)

12. Field #12: Insurance Plan Name

Positions: 80-104
Characters: 25, alpha
Justification: left

Enter ADHS PCP

13. Field #13: Name of Referring Physician

Positions: 105-130
Characters: 26, alpha
Justification: left

14. Field #14: ID # of Referring Physician

Positions: 131-136
Characters: 6, numeric
Justification: right

15. Field #15: Diagnosis Code 1 (Required Field)

Positions: 137-142
Characters: 6, numeric
Justification: left

This diagnosis code (ICD-9) corresponds to the primary diagnosis and should be exact. Use of descriptor codes in this field increase the error rate and cause the billable claim to fail the validation process. Example: The code for depressive disorder NOS is 311 and should be keyed as 311 (not 311., 311.0 or 311.00).

16. Field #16: Diagnosis Code 2

Positions: 143-148
Characters: 6, numeric
Justification: left

This diagnosis code (ICD-9) should be the secondary diagnosis. See example for field #15

17. Field #17: Diagnosis Code 3

Positions: 149-154
Characters: 6, numeric
Justification: left

This diagnosis code (ICD-9) should be the third diagnosis.
See example for field #15.

18. Field #18: Diagnosis Code 4

Positions: 155-159
Characters: 6, numeric
Justification: left

This diagnosis code (ICD-9) should be the fourth diagnosis. See example for field #15.

19. Field #19: Date of Encounter (Required Field)

Positions: 161-168
Characters: 8, numeric
Justification: left

This field is the date that the patient received services at your clinic. Please key the date without any slash marks (07012002). Example: Date Format: MMDDYYYY

20. Field #20: 1st Procedure CPT/HCPCS (Required Field)

Positions: 174-175

Characters: 5, numeric
Justification: left

This field is the billable code as specified by the Program Guidance Manual.

21. Field #21: 1st Procedure Modifier 1

Positions: 174-175
Characters: 2, numeric
Justification: left

This field must be a valid American Medical Association code.

22. Field #22: 1st Procedure Modifier 2

Positions: 176-177
Characters: 2, numeric
Justification: left

This field should be a valid AMA code.

23. Field #23: Diagnosis Code (Warning if missing)

Position: 178-181
Characters: 4, numeric
Justification: left

This field indicates the diagnosis code (fields 15-18) to which the procedure code (CPT/HCPCS) applies.

24. Field #24: Charges

Position: 182-187
Characters: 6, numeric
Justification: right

Please round the charge for the first procedure to the nearest whole dollar. Do not use the dollar symbol. Example: If the charge is $56.00, key it as 000056 (if necessary, add leading zeros so that all six spaces are filled).

25. Field #25: 2nd Procedure CPT/HCPCS

Positions: 188-192
Characters: 5, numeric
Justification: left

This code represents the second procedure performed on the patient.

26. Field #26: 2nd Procedure Modifier 1

Positions: 193-194
Characters: 2, numeric
Justification: left

This field should be a valid AMA code.

27. Field #27: 2nd Procedure Modifier 2

Positions: 195-196
Characters: 2, numeric
Justification: left

Please use a valid AMA code.

28. Field #28: Diagnosis Code (Warning if missing**)**

Positions: 197-200
Characters: 4, numeric
Justification: left

This field indicates the diagnosis code (fields 15-18) to which the procedure code (CPT/HCPCS) applies.

29. Field #29: Charges

Positions: 201-206
Characters: 6, numeric
Justification: right

The charge for the service (procedure) should be rounded to the nearest whole dollar. Do not use the dollar symbol. Example: A charge of $56.00 should be keyed as 000056 (if necessary, add leading zeros)

30. Field #30: 3rd Procedure CPT/HCPCS

Positions: 207-211
Characters: 5, numeric
Justification: left

This field should be a billable code as defined by the Program Guidance Manual.

31. Field #31: 3rd Procedure Modifier 1

Positions: 212-213
Characters: 2, numeric
Justification: left

This field should be a valid AMA code.

32. Field #32: Procedure Modifier 2

Positions: 214-215
Characters: 2, numeric
Justification: left

This field should be a valid AMA code.

33. Field #33: Diagnosis Code (Warning if missing)

Positions: 216-219

Characters: 4, numeric
Justification: left

This field indicates the diagnosis code (fields #15-18) to which the procedure code (CPT/HCPCS) applies.

34. Field #34: Charges

Positions: 220-225
Characters: 6, numeric
Justification: right

Round the number to the nearest dollar. Do not use the dollar symbol. Example: Key a charge of $56.00 as 000056 (if necessary, add leading zeros).

35. Field #35: 4th Procedure CPT/HCPCS (Required Field)

Positions: 226-230
Characters: 5, numeric
Justification: left

This field should be a billable code as defined by the Program Guidance Manual.

36. Field #36: 4th Procedure Modifier 1

Positions: 231-232
Characters: 2, numeric
Justification: left

This field should be a valid AMA code.

37. Field #37: 4th Procedure Modifier 2

Positions: 233-234
Characters: 2, numeric
Justification: left

This field should be a valid AMA code.

38. Field #38: Diagnosis Code (Warning if missing)

Positions: 235-238
Characters: 4, numeric
Justification: left

This field indicates the diagnosis code (fields #15-18) to which the procedure code (CPT/HCPCS) applies.

39. Field #39: Charges

Positions: 239-244
Characters: 6, numeric
Justification: right

Round the number to the nearest whole dollar. Do not use the dollar symbol.
Example: A charge of $56.00 should be keyed as 000056 (if necessary, add leading zeros).

40. Field #40: 5th Procedure CPT/HCPCS (Required Field)

Positions: 245-249
Characters: 5, numeric
Justification: left

This field should be a billable code as defined by the Program Guidance Manual.

41. Field #41: 5th Procedure Modifier 1

Positions: 250-251
Characters: 2, numeric
Justification: left

This field requires a valid AMA code.

42. Field #42: 5th Procedure Modifier 2

Positions: 252-253
Characters: 2, numeric
Justification: left

This field requires a valid AMA code.

43. Field #43: Diagnosis Code (Warning if missing)

Positions: 254-257
Characters: 4, numeric
Justification: left

This field indicates the diagnosis code (fields #15-18) to which the procedure code (CPT/HCPCS) applies.

44. Field #44: Charges

Positions: 258-263
Characters: 6, numeric
Justification: right

Round the number to the nearest whole dollar. Do not use the dollar symbol. Example: A charge of $56.00 should be keyed as 000056 (if necessary, add leading zeros).

45. Field #45: 6th Procedure CPT/HCPCS (Required Field)

Positions: 264-268
Characters: 5, numeric
Justification: left

This field should be a billable code as defined by the Program Guidance Manual.

46. Field #46: 6th Procedure Modifier 1

Positions: 269-270
Characters: 2, numeric
Justification: left

This field should be a valid AMA code.

47. Field #47: 6th Procedure Modifier 2

Positions: 271-272
Characters: 2, numeric
Justification: left

This field requires a valid AMA code.

48. Field #48: Diagnosis Code (Warning if missing)

Positions: 273-276
Characters: 4, numeric
Justification: left

This field indicates the diagnosis code (fields #15-18) to which the procedure code (CPT/HCPCS) applies.

49. Field #49: Charges

Positions: 277-282
Characters: 6, numeric
Justification: right

Round the number to the nearest whole dollar. Do not use the dollar symbol. Example: A charge of $56.00 should be keyed as 000056 (if necessary, add leading zeros).

50. Field #50: Total Charges

Positions: 283-289
Characters: 7, numeric
Justification: right

This field is the total charges for the visit. Round the total to the nearest whole dollar. Do not use the dollar symbol. Example: Key a total charge of $256.00 as 0000256 (if necessary, add leading zeros).

51. Field #51: Amount Paid

Positions: 290-296
Characters: 7, numeric
Justification: right

Round the amount to the nearest whole dollar. Do not use the dollar symbol. Example: If the patient paid $20.00, key it as 0000020 (if necessary, add leading zeros).

52. Field #52: Balance Due

Positions: 297-303
Characters: 7, numeric
Justification: right

This field is the remaining dollar amount that is still owed for the visit. Round the balance to the nearest whole dollar. Do not use the dollar symbol. Example: A charge of $56.00 should be keyed as 0000056 (if necessary, add leading zeros).

53. Field #53: Facility Site Number (Required Field)

Positions: 304-308
Characters: 5, numeric
Justification: left

The first two digits are assigned to the contractor by HSD. From left to right the third (3rd) and fourth (4th) positions indicate the individual clinic operating under the contracted organization. Each clinic is given its own site id number that corresponds to the clinic's address. If a clinic's location changes, a new number is assigned to it. The numbers are fixed geographically and cannot be used again unless the contractor re-opens the same clinic at the same address.

Example: 99000 – This number is assigned to the main contractor.
99001 – This number is assigned to a clinic and is issued in descending order for each additional clinic.

54. Field #54: Physician's ID

Positions: 309-320
Characters: 12, numeric
Justification: right

This number is the physician's license number from the state BOMEX system. Add leading zeros to complete the field. Example: Dr. Johnson's state license number from BOMEX is 53729. Key it as: 000000053729

55. Field #55: Physician's First Name and MI

Positions: 321-332
Characters: 12, numeric
Justification: left

This field should be keyed as follows: Marion J. (first name, space, middle Initial)

56. Field #56: Physician's Last Name

Positions: 333-352
Characters: 20, numeric
Justification: left

Do not key anything after the last field. Additional information will cause the claim to fail the pre-check.

APPENDIX L
EPSDT PERIODICITY SCHEDULE

Procedures	Infancy								Early Childhood					Middle Childhood			Adolescence					
	new born	2-4 day	by 1 mo	2 mo	4 mo	6 mo	9 mo	12 mo	15 mo	18 mo	24 mo	3 yr	4 yr	5 yr	6 yr	8 yr	10 yr	12 yr	14 yr	16 yr	18 yr	20+ up to 21 yr
History Initial/Interval	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Height & Weight	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Head Circumference	x	x	x	x	x	x	x	x	x	x	x											
Blood Pressure												x	x	x	x	x	x	x	x	x	x	x
Nutritional Assessment	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Vision**																						
Hearing**/Speech																						
Dev./Behavioral Assess.	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Physical Examination	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Immunization	x ◄	►	►	x	x	x		◄	x	►			◄	x	►			x ◄	►	►	►	
Tuberculin Test								+	+	+	+	+	+	+	+	+	+	+	+	+	+	+
Hematocrit/Hemoglobin			◄	►	►	►	x												x	►	►	►
Urinalysis														x					x	►	►	►
Lead Screening																						
Verbal						x	x		x	x		x	x	x	x							
Blood								x			x	x*	x*	x*	x*							
Anticipatory Guidance	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Dental Referral**																						

These are minimum requirements. If at any time other procedures, tests, etc. are medically indicated, the physician is obligated to perform them. If a child comes under care for the first time at any point on the schedule, or if any items are not accomplished at the suggested age, the schedule should be brought up to date at the earliest possible time.

Key: x = to be completed
\+ = to be performed for members at risk when indicated.
◄x► the range during which a service may be provided, with the **x** indicating the preferred age.

* Members not previously screened who fall within this range (36 to 72 months of age) mu st have a blood lead screen performed.
** See separate schedule for detail.
*** If American Academy of Pediatrics guidelines are used for the screening schedule and/or more screenings are medically necessary, those additional interperiodic screenings will be covered.

Source: Arizona Health Care Cost Containment System (AHCCCS)
Available: http://www.ahcccs.state.az.us/Regulations/OSPpolicy/chap400/ex430_1.pdf
Date of Access: 10/22/2004

APPENDIX L
EPSDT PERIODICITY SCHEDULE

VISION PERIODICITY SCHEDULE

			MONTHS									YEARS										
Procedure	New born	2 – 4 days	by 1 mo	2	4	6	9	12	15	18	24	3*	4	5	6	8	10	12	14	16	18	20 + up to 21 years
Vision +++	**S**	**S**	**S**	**S**	**S**	**S**	**S**	**S**	**S**	**S**	**S**	**O**	**O**	**O**	**S**	**S**	**O**	**O**	**S**	**S**	**O**	**S**

These are minimum requirements: If at any time other procedures, tests, etc. are medically indicated, the physician is obligated to perform them.

Key: S = Subjective, by history
O = Objective, by a standard testing method
*** = If the patient is uncooperative, rescreen in 6 months.**
+++ = May be done more frequently if indicated or at increased risk.

HEARING AND SPEECH PERIODICITY SCHEDULE

			MONTHS									YEARS										
Procedure	New born	2 – 4 days	by 1 mo	2	4	6	9	12	15	18	24	3	4	5	6	8	10	12	14	16	18	20 + up to 21 years
Hearing/ Speech+++	**S/O**	**S**	**S**	**S**	**S**	**S**	**S**	**S**	**S**	**S**	**S**	**O**	**O**	**O**	**S**	**S**	**O**	**O**	**S**	**S**	**O**	**S**

These are minimum requirements: If at any time other procedures, tests, etc. are medically indicated, the physician is obligated to perform them.

Key: S = Subjective, by history
O = Objective, by a standard testing method
*** = All children, including newborns, meeting risk criteria for hearing loss should be objectively screened.**
+++ = May be done more frequently if indicated or at increased risk.

Source: Arizona Health Care Cost Containment System (AHCCCS)
Available: http://www.ahcccs.state.az.us/Regulations/OSPpolicy/chap400/ex430_1.pdf
Date of Access: 10/22/2004

APPENDIX L
EPSDT PERIODICITY SCHEDULE

DENTAL PERIODICITY SCHEDULE

		YEARS																
Procedure	Birth thru 36 months	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20 + up to 21 years
Dental Referral	+	**x**	**x**	**x**	**x**	**x**	**x**	**x**	**x**	**x**	**x**	**x**	**x**	**x**	**x**	**x**	**x**	**x**	**x**

Referrals for routine dental visits should begin at age three(3). Earlier initial dental evaluations may be appropriate for some children. Subsequent examinations as prescribed by dentist.

Key: + = birth to 36 months if indicated
x = to be completed

Source: Arizona Health Care Cost Containment System (AHCCCS)
Available: http://www.ahcccs.state.az.us/Regulations/OSPpolicy/chap400/ex430_1.pdf
Date of Access: 10/22/2004

APPENDIX M
ADULT PERIODICITY SCHEDULE

YEARS OF AGE		18	25	30	35	40	45	50	55	60	65	70	75 +
TESTS:	**BLOOD PRESSURE**	EVERY 2 YEARS											
	HEIGHT & WEIGHT	PERIODICALLY											
	CHOLESTEROL				EVERY 5 YEARS								
	HEARING										PERIODICALLY		
	MAMMOGRAPHY							EVERY 1-2 YEARS (WOMEN)					
	PAP SMEAR	EVERY 1-3 YEARS (WOMEN)											
	PROSTATE-SPECIFIC ANTIGEN							YEARLY (MEN)					
	SIGMOIDOSCOPY							EVERY 3-5 YEARS					
	STOOL OCCULT BLOOD							YEARLY					
	URINALYSIS									PERIODICALLY			
EXAMS:	**DENTAL**	YEARLY											
	VISION/GLAUCOMA					EVERY 2-4 YEARS				EVERY 2 YEARS			
	BREAST (Women)	EVERY 1-3 YEARS				YEARLY							
	EXAMS FOR CANCER Thyroid, Mouth, Skin, Ovaries, Testicles, Lymph Nodes, Rectum (40+), Prostate (men 50+)	EVERY 3 YEARS				YEARLY							
IMMUNIZATIONS:	**TETNUS-DIPHTHERIA**	EVERY 10 YEARS											
	PNEUMOCOCCAL										ONCE		
	INFLUENZA										YEARLY		
HEALTH GUIDANCE	Smoking, Alcohol & Drugs, Sexual Behavior, AIDS, Nutrition, Physical Activity, Violence & Guns, Family Planning, Injuries, Occupational Health, Folate (women 12-45), Asprin (men 40+), Estrogen (women 45+)	PERIODICALLY											

KEY: Recommended by all major authorities
Recommended by some major authorities

*Upper age limits should be individualized for each person

Source: Arizona Health Care Cost Containment System (AHCCCS)
Available: http://www.ahcccs.state.az.us/Regulations/OSPpolicy/chap400/ex430_1.pdf
Date of Access: 10/22/2004